COUNTY COUNCIL OF CUMBERLAND

Annual Report

ON THE

HEALTH SERVICES OF THE COUNTY

For the Year 1954

KENNETH FRASER,
M.D., F.R.S.E., D.P.H., D.T.M.,
COUNTY MEDICAL OFFICER.

INDEX

TO THE CHAIRMAN AND MEMBERS OF THE CUMBERLAND COUNTY COUNCIL

Mr. Chairman, My Lord, Ladies and Gentlemen,

I beg to present the annual report on the Health Services for 1954.

This is the last report I will have the honour of submitting to you as I retire in the early summer of 1956. By that time I will have been in your service for 44 years. The only reason why I mention these points is to explain why I have thought that it might be of some interest to do a little bit of stocktaking of the position past, present, and future, and to include as I have done a little bit of history and some graphs showing the progress of certain of the vital statistics over the last twenty-five years.

Looking Back

The Education Administrative Provisions Act of 1907 made it obligatory on Education Authorities to provide for the medical inspection of children attending the elementary schools in the area of the authority. The step arose out of the national concern about the poor physique of large numbers of young men which was brought to light during the process of recruitment arising out of the South African War. The appointment of a County Medical Officer which had been permissive under the Local Government Act of 1888 became obligatory on County Councils by the Housing Town Planning, etc., Act, 1909, which, of course, also required County Councils to appoint health committees and open health departments. This step was a natural sequence of the institution of the medical inspection of school children.

The County Health Department opened in 1908, the first meeting of the Health Committee being held in January, 1909, under the chairmanship of the late Viscount Morpeth. The Committee consisted of 12 members. The committee was formed under the following minute of the council—

"Resolved, that the special joint committee of the Finance, General Purposes and Education Committees appointed to deal with the appointment of a county

medical officer of health be continued as a standing committee of the council, and be called 'The Health Committee.'"

The first office utilised for the work of the department consisted of two small rooms up a stair in Devonshire Street, Carlisle, and the staff, shortly after the department opened, consisted of the medical officer, two assistant school medical officers, two nurses and one clerk, with the part-time services of the county superintendent of nursing employed by the Cumberland Nursing Association to supervise the school nursing in the first instance.

I believe it is historically true to say that the member of the council who moved that a health department be opened, assured the council that at no time would the cost of the department to the council exceed £1,000 per annum. Our estimated expenditure for the current financial year is £266,000, and the staff today numbers 209. The mere fact that a department has expanded in expenditure and in staff employed of itself means nothing. The only criterion is value for money expended and staff employed.

The first report of my predecessor (Dr. F. H. Morison) was issued in respect of the year 1908. The following statistics extracted from the report are of interest in comparison with the figures for 1954, the year under review.

	1908	1954
Population	224,749 (after deducting the figures for the borough of Carlisle)	216,600
No. of sanitary districts in the county	24 (15 urban, 9 rural)	13 (6 urban, 7 rural)
Total births registered	7,158 (including Carlisle)	3,355
Birth rate per 1,000 population ...	26.04 (one or two districts had birth rates of over 32 per 1,000 population)	16.4
Death rate per 1,000 population ...	15.3	11.9
Infantile mortality rate per 1,000 births ...	126 (in one district the rate reached 172 per 1,000 births)	27.6

Total deaths of infants under 1 year ...	906	98
Notifications of diphtheria	236 with 43 deaths	Nil
Notifications of puerperal fever/puerperal pyrexia ...	13 with 12 deaths	34 (puerperal pyrexia. No deaths)
Notifications of typhoid fever	251 with 37 deaths	Nil
Deaths from pulmonary tuberculosis ...	282	26

The bulk of the report is concerned with water supplies, sewage and refuse disposal, infectious diseases hospitals, and slaughter houses, in other words, with the problems of general sanitation.

It is not mentioned in my predecessor's report, but I have myself in a previous report referred to the fact that in two of the isolation hospitals (which had between them an aggregate of, I think, well over 300 beds), in one case the matron was the wife, and in another case the widow, of the porter, and in at least one case the matron habitually slept in the scarlet fever ward and took the patients' pulse rates by means of an alarm clock.

All sorts of interesting comments appear in this and the early subsequent reports of my predecessor, of which the following is quite typical—" In the Borough of Whitehaven the refuse is collected two or three times a week and is taken out to sea in hoppers."

The standard of domiciliary midwifery left much to be desired and many unqualified women of the Sarah Gamp type had quite extensive practices among the poorer classes of the community.

One could go on almost indefinitely extracting interesting items from the now distant past, but the examples I have given may serve, because comparatively early, as a result of succeeding legislation, the work of the county health department rapidly passed from the general—water and sewage, infectious diseases hospitals, slaughter houses, nuisances, and so on—to the personal aspect.

As I joined the department very shortly after it opened I have been in a position to follow progress and changes through the years. These began, of course, with

the medical inspection of elementary school children. The next step was the opening of the campaign against tuberculosis. The power (which later became a duty) to provide treatment for school children, including a dental service, later extended these provisions to secondary school children. There followed at various times, and not necessarily in the order which I give them, the opening of tuberculosis dispensaries and school clinics, the initiation of a maternity and child welfare service, the treatment of venereal disease, and so on. Our first tuberculosis dispensary and school clinic was opened in Penrith in 1912 and after serving its purpose well for some 40 years, has just been replaced by a modern clinic building.

Some of the chief legislative landmarks during the years have been the Education Acts of 1921 and 1944, the Local Government Act 1929, under which the number of sanitary districts were reduced by consolidation from 24 to 13, the Midwives Act of 1936, and the National Health Service Act of 1946, which by transferring *to* the health department responsibility for the ambulance, home help, immunisation and mental health services, and tranferring *from* it to regional boards the hospitals, brought about another major switch, this time not to the personal side but from the personal to the administrative.

One other important service which occupied the attention of the health department for many years was the control, or at least a large share in the control of milk production and distribution, which has of course now been transferred to the Ministry of Agriculture.

During the years 1920-1948 when the National Health Service Act came into operation, the department established close contact with hospitals in all parts of the country from places as far apart as London and Edinburgh including hospitals in Manchester, Leeds, Oswestry and many other places. The hospitals to which we sent cases suffering from many different diseases were arrived at by a process of careful selection. The cases were in a large measure referred to us by general practitioners in the county who sought our co-operation in the hospitalisation of their cases. The figures involved were substantial. In one branch alone, orthopaedics, in which our county clinics came to be regarded as the recognised "clearing house," especially for children, we must in the period have

dealt with not less than 15,000 cripples of all degrees of severity of whom a very large number received hospital treatment at the orthopaedic hospital at Oswestry or at the Ethel Hedley Hospital, Windermere, this treatment in some cases covering periods as long as three years.

We sent most of our cancer cases to Manchester, although some went to the Westminster Hospital, London, for special treatment. We sent large numbers of cases of adults to the Royal Infirmary, Edinburgh, and children to the Royal Hospital for Sick Children in the same city.

Looking at the Present

I think that the health services of the county today may be regarded as reasonably complete. We have, for an area in which the product of a penny rate does not stand at a very high figure, been able to keep abreast of modern standards. We have, I think, adequately provided for our legal responsibilities under the National Health Service Act. We have, for example, completely re-equipped the ambulance service with new vehicles. We have gone or will shortly have gone a long way towards the provision of modern clinics and treatment centres over the county. We have been perhaps a little unorthodox in certain directions. For example, we have linked up the nursing and home help services under the supervision of the Superintendent Nursing Officer; our ambulance and sitting case car service is quite off the general pattern, but both these " diversions " have proved in practice to work efficiently and economically. We have, I hope, in a few matters been a little bit ahead of the times.

The one great distinction between the past and the present is that since the passing of the National Health Service Act our contacts with hospitals and general practitioners are much less close than they used to be. This is, of course, a matter for regret, and the inevitable result is that we have to a considerable extent lost our grip, particularly in respect of disabilities affecting our school children and the children under school age, and on what is happening about these disabilities. We are therefore less able than we were to give effective advice on the educational and other problems of certain groups of children.

One matter which we can regard with unqualified satisfaction lies in the happy relationships between the authority on one hand, and the Special Area Committee for Cumberland, Carlisle, and North Westmorland, and the Hospital Management Committees on the other. The advantages of this co-operation have been, and continue to be, mutual. For this happy co-operation we have been largely indebted to the late Mr. Harston, the first chairman of the Special Area Committee, and to Mr. Venters, the present chairman, to the members of the committee, and to the Senior Administrative Medical Officer of the Newcastle Regional Hospital Board, Dr. W. G. Patterson, and to his colleagues. You were good enough to allow me, when the National Health Service Act came into operation, to accept the office of Administrative Medical Officer to the Special Area Committee, and the resulting liaison may have been of some value.

Looking Ahead

For obvious reasons I have the advantage of being able to write in this matter from the angle of one who is not personally concerned.

One of the chief problems which faces the public health service in the years ahead is the marked discrepancy between the rates of remuneration paid to the medical officers in the public health service, and to the medical personnel employed in other branches of medicine, particularly those in the hospital service and in general practice. This particularly perhaps is true in respect of those medical men and women in the public health service who do not hold and who are never likely to hold senior posts. The recent award of the Industrial Court, due, I am afraid, to the short sighted policy of the management side, resulted in an increase in the starting salary figure of £25, and in an increase of £75 when the assistant medical officer has reached his maximum figure after seven years. This is, quite bluntly, chicken feed, and the inevitable result will be that good candidates for the public health service will cease to appear.

The policy of the management side (the County Councils Association and the Association of Municipal Corporation) has been that remuneration in the public health service should be measured against the yard stick of other officers in local government. That may of

course seem a perfectly reasonable argument, but it is of course of no interest whatsoever to the young graduate in medicine when the time comes for him to select which special branch of medicine he will follow as his profession. He naturally does not compare the remuneration in the public health service with the remuneration of other officers in local government, of which he is probably quite unaware, but he compares the remuneration lying ahead for him as between one branch of medicine and another, and he is naturally not likely to select the least well remunerated branch of medicine.

That the medical profession as a whole are not unaware of, or undisturbed by, this discrepancy was made very plain indeed at the recent Annual Representative Meeting of the British Medical Association, which adopted the following resolution :—

> " That in view of the dangers presented to the medical profession by the low levels of remuneration in the salaried medical services of the State and local authorities, steps be taken urgently by the Association to bring the remuneration of the medical personnel in these services to a level comparable to that of the rest of the profession engaged in hospital and general practice."

At this meeting Dr. H. Guy Dain, a general practitioner who has achieved high distinction in the councils of the profession, said that if Britain had a preventive service which was so badly conditioned that doctors would not enter it, that was bad for the public. He went on to say that a general practitioner could treat a person: a medical officer might be able to raise the level of health of a whole community.

The statistics which I have quoted earlier under the heading " Looking Back," might seem to indicate that the public health service by its efficiency, in conjunction with other branches of medicine, has gone a long way to cut its own throat, but everyone concerned with public health realises very well that there is a wide field of preventive medicine lying ahead, in some aspects yet untapped, in which the public health organisation can render outstanding service to the nation.

Today the National Health Service falls into three main branches :—

The hospital service,

The general practitioner (including dental) service, and

The local authority service.

The work of these three branches is administered by a multiplicity of parent bodies and committees and of sub-committees. If one considers all the aspects of the health services today, hospitals, general practice, local authority, including housing and sewage and water schemes, and the many voluntary bodies who also play some part, such, for example, as the moral welfare bodies who administer homes for unmarried mothers and so on, one calculates that in this small corner of England which comprises the Special Area, there can hardly be fewer than 100 parent bodies, committees, and sub-committees dealing with health matters from one aspect or another. The report of the Guillebaud Committee set up some two years ago with wide terms of reference to report on the cost of the National Health Service, will surely have something to say about the multiplication of organisations dealing with the national health in one way or another, and with the overlapping which inevitably results, and with the impossibility of achieving co-operation and cohesion from so unwieldly a structure.

Care of the Aged

There are in Cumberland more than 20,000 people of the age of 65 years or over. That means that about one person in ten of the population is " aged " according to the generally accepted yardstick. These numbers will, of course, in the years ahead show a sharp increase, and the problem of the care of the aged is bound in the time ahead to force itself upon the attention of local authorities to a greater extent than it does at the moment.

I think it is true to say that in this county there is very great interest taken in this question. I thought a member of the council at a committee meeting at which the question of building additional specially designed hostels for the aged came up, put it very well when he said something like this—" We have done well by the children and we must not fail to see that the old folk

get their fair share of our attention." The County Welfare Officer in his section of the report will deal with several aspects of this problem, perhaps particularly with the institutional side, and will explain the policy of building hostels in various parts of the county and of adapting existing buildings for this purpose, which has been adopted by the County Council, and will explain the progress made to date.

Apart from this aspect of the matter, quite a lot is being done for the welfare of the aged in this county. Last year I referred to the interest of the County Federation of Women's Institutes in this matter whereby, arising from a series of conferences, the Women's Institutes throughout the county have appointed members to act as unofficial friends of the aged to help with their day-to-day domestic problems where help is needed. These friends of the aged, who represent some 75 Women's Institutes, work in conjunction with the district nurses to this end. A great deal is, of course, done by the home help service and by the nursing service for the comfort and well-being of the aged in their own homes. During 1954 something in the region of 300 old persons were helped, mostly for long periods and many throughout the whole year, by the home help service.

During the early part of the current year the question of the provision of a night sitter service received the consideration of the council, and as a result a conference was called between members of the council and representatives of voluntary associations such as the Federation of Women's Institutes, the Women's Voluntary Services, the British Red Cross, the St. John Ambulance Association, and, of course, the Old People's Welfare Committee, and representatives of associations of one kind and another for the welfare of the aged from different parts of the county. It is accepted that to provide a home help to an elderly person who may be seriously disabled by blindness, arthritis, or for some other reason for so many hours a day, leaving the old person alone throughout the night hours, cannot be regarded as a real solution of the problem of the individual. The conference was therefore called to see how far the major voluntary organisations in the county could help to solve this problem by finding among their numbers persons willing to act as night sitters. It is appreciated that, just as many mothers get worn out

and exhausted by constant attention to low grade mental defective children, and just as the provision of occupation centres gives these worn out mothers some substantial measure of relief from the strain, so in the case of elderly and infirm persons living alone there is often a great strain on relatives who may for quite long periods have to sit up at night, or at least be on call throughout the night in case of need. One important aspect of the night sitter service is that these relatives, who are also liable to become worn out by the strain, should be allowed to have a night or two nights a week off through the good offices of kindly folk who will bear a hand with the problem. The only direct result so far to hand has come from Alston where the local Old People's Welfare Committee has formed a panel of six members (capable of expansion if the need justifies it) who are prepared to act as night sitters should the need arise. This is a very fine gesture by the people of Alston and I hope this will lead to similar panels being formed in many other parts of the county.*

Finally in the important matter of housing, a reference to the little section on housing later in the report will show that the housing authorities, that is to say the district councils, in the county have provided nearly 500 houses, bungalows, or flats specifically for old people, these being generally of the one or two bedroom type.

All this means that quite a lot is being done in the county for the welfare of the aged, but of course a great deal remains to be done, and undoubtedly one service which would be generally welcomed would be the provision of chiropody on a domiciliary basis to the aged. A questionnaire sent out to all district nurses in the county some fifteen months ago showed that this is generally accepted as one of the outstanding needs.

**Since the above was dictated the Cockermouth branch of the Cumberland Old People's Welfare Committee have intimated their willingness to help in this service "in any way possible."*

The Cumberland Federation of Women's Institutes have also sent in the names of a number of their members who are willing to take part in this service.

All this means that the conference above referred to is bearing fruit, and that the scheme is gradually taking shape.

Distribution of Welfare Foods

During the year we took over at rather short notice from the Ministry of Food the distribution of welfare foods in the administrative county. The volume of the turnover is not very large compared with some other areas. Something like 300,000 tins of dried milk, bottles of orange juice, bottles of cod liver oil and boxes of vitamin tablets are distributed annually.

The real problem in a county of this type is the number of distribution centres involved. These amount to 111 of which no less than 103 are operated by the Women's Voluntary Services. We were under a great obligation to the County Organiser, Mrs. Wright-Brown, and to her area organisers and to the members of the Women's Voluntary Services co-operating in this matter for the immense help they have given us and are continuing to give. Without their help we should have been really up against it.

In most of the urban areas distribution centres have been arranged with private firms. The whole system of distribution has now, after a few initial difficulties here and there, settled down, and is working smoothly and well.

Special Reports

It may be of interest to refer for a moment to a step which has been taken in order to enable us to have more accurate information about the disabilities affecting children of school age and under school age, than we have previously had. With this object in view I have asked all nurses on the County Council staff to complete the following report form when the circumstances of the case appear to justify this.

One of the chief objects in calling for these reports from the nurses is to enable us to deal with the special educational problems of physically handicapped children and even to plan well ahead in conjunction with the Director of Education to meet the special needs of the handicapped child.

The survey also enables us to become aware of children of low mentality of whose existence we would otherwise not have known, and to bring them under the care of the mental health section for occupation centre training or otherwise.

During the few months in which this form has been in operation, a great deal of most valuable information has been received from some 350 reports.

It will be noted that the form asks in every case for the name of the family doctor. That we regard as of the first importance so that we can obtain the approval of the family doctor to any steps which it is proposed to take in any individual case.

Health Card Ref. No.: .....

CUMBERLAND COUNTY COUNCIL

(HEALTH DEPARTMENT)

Date: .....

Special report on physically or mentally handicapped children including children who need or may need special educational provision, or are children neglected in their own homes or who, because of their housing conditions, or for other reasons, require further investigation.

The following child falls in the above category:—

Name: .....

Address: .....

Date of Birth: ..... Name of Family Doctor : .....

School attended (if any): .....

State here the reasons why the case requires special attention:

.....

.....

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.....

Note of any action taken, for example hospital treatment, or specialist examination, known to the nurse:—

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.....

Date ....

Health Visitor or District Nurse.

Summary

You have asked me to bring to your notice each year the points in the annual report to which I think your attention should particularly be drawn. This year I think the section on the mental health service, in the preparation of which I have been greatly indebted to Mr. Froggatt, the Mental Health Officer, is worth careful study. The general remarks on the nursing services, pages 34 to 38, contain points of interest. In view of the general interest in spastics the brief notes on page 86 should be studied.

The whole section on tuberculosis and disease of the chest, which includes very interesting reports from the consultant chest physicians, is of course of great interest. Although it is only in an indirect way our concern, I would like to draw attention to the comments on the progress of the mass miniature radiography service, and particularly to table 2 in Dr. Morton's report. This shows that during the year 44,471 persons were examined by mass miniature radiography and active pulmonary tuberculosis was diagnosed in 149 cases. Sixty-one cases of bronchiectasis were found and 12 cases of cancer of the lung as well as a large number of cases of pneumoconiosis in West Cumberland and of cardiac conditions of one kind and another in both areas. Why I draw attention to this particularly is that as Dr. Morton has explained in his covering notes, the response to the offers of examination by mass miniature radiography have been in certain respects unsatisfactory in spite of intensive propaganda. Anything we can do to emphasise the value of this service in the community should be done.

The Deputy County Medical Officer, Dr. Minto, submits a valuable memorandum on the experimental Mantoux testing of school entrants in the autumn of 1954. This memorandum by Dr. Minto is not only of itself of great interest, but enables me to pay a tribute to Dr. Minto in that only a few months after he had taken up his duties as deputy county medical officer he organised from scratch the whole of this Mantoux testing investigation, and also the Mantoux testing and B.C.G. vaccination of the 13 year old age group of school children. This has been a most complicated matter involving many schools and many personal con-

tacts, and handling a difficult piece of administration like this so soon after his arrival in the county represents a very fine piece of work.

Finally, I would also draw your attention to the section on the welfare services by the County Welfare Officer.

Thanks

When anyone vacates office after a long spell, he naturally thinks with gratitude of the help he has received in the carrying out of his duties down the years. I have served under four chairmen of the Health Committee—Lady Mabel Howard, Colonel Dykes, Lord Adams and Mr. Dickinson—and I have always been grateful for the backing they have given me. I am grateful too to successive Health Committees who have throughout given me unqualified support. I have been much indebted to my colleagues in other departments of the County Council.

With regard to my own staff, I suppose no-one conversant with the working of the department would query my first expressing my indebtedness to my Administrative Officer, Mr. Butcher, who has been a central pivot of the department's work for 30 years. Nor must I forget Miss Lamb, who has been the head of the women's section of the clerical staff for the same period. I am grateful for the help I have received from Dr. Jones, Dr. Hunter and Dr. Thomson, who have been members of the medical staff of the council for long periods. I am grateful to the heads of sections; to Mr. Martin as Senior Dental Officer and for his invaluable work in the running of the ambulance service; to Miss Mansbridge who carries the heavy responsibility of head of the nursing and home help sections; to Mr. Froggatt who has maintained the efficiency of the mental health section at a high level; to Miss Morris who took over the care of our cripple children from Miss Nelson, who had carried on this work for more than 20 years. The work of all sections of the nursing staff had been admirable throughout. The clerical staff, with the headquarters section of which I have naturally been most closely associated, have never failed to respond to the demands, sometimes perhaps not very reasonable and often at personal inconvenience, made

on them at times of stress which have been by no means infrequent.

Summing it all up, my successor will take over as good a team as any man could wish for.

I am, my Lord, Ladies and Gentlemen,

Your obedient Servant,

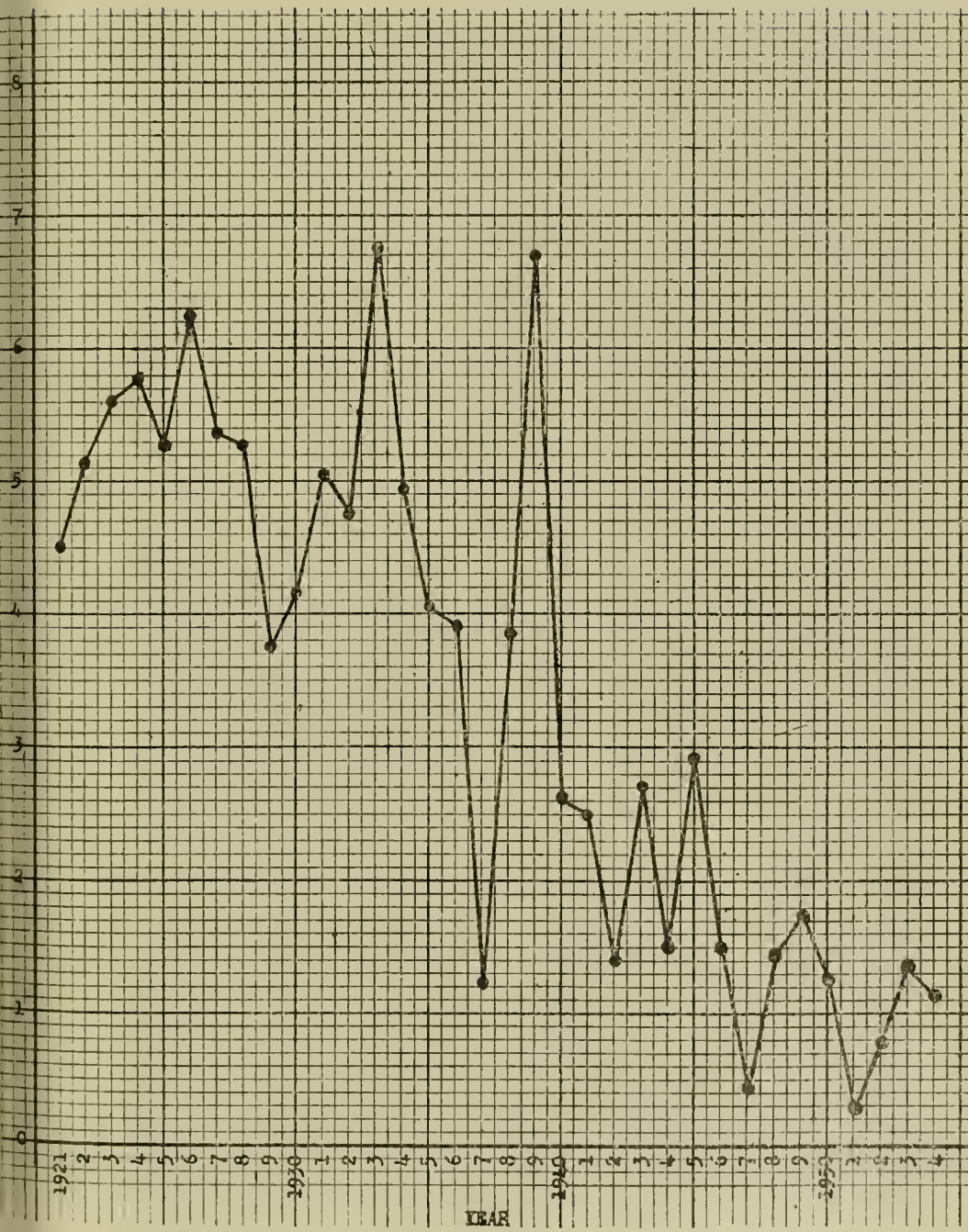
KENNETH FRASER,
County Medical Officer.

County Health Department,
11 Portland Square,
Carlisle.
June, 1955.

MATERNAL MORTALITY

Death Rate Per 1,000 Births

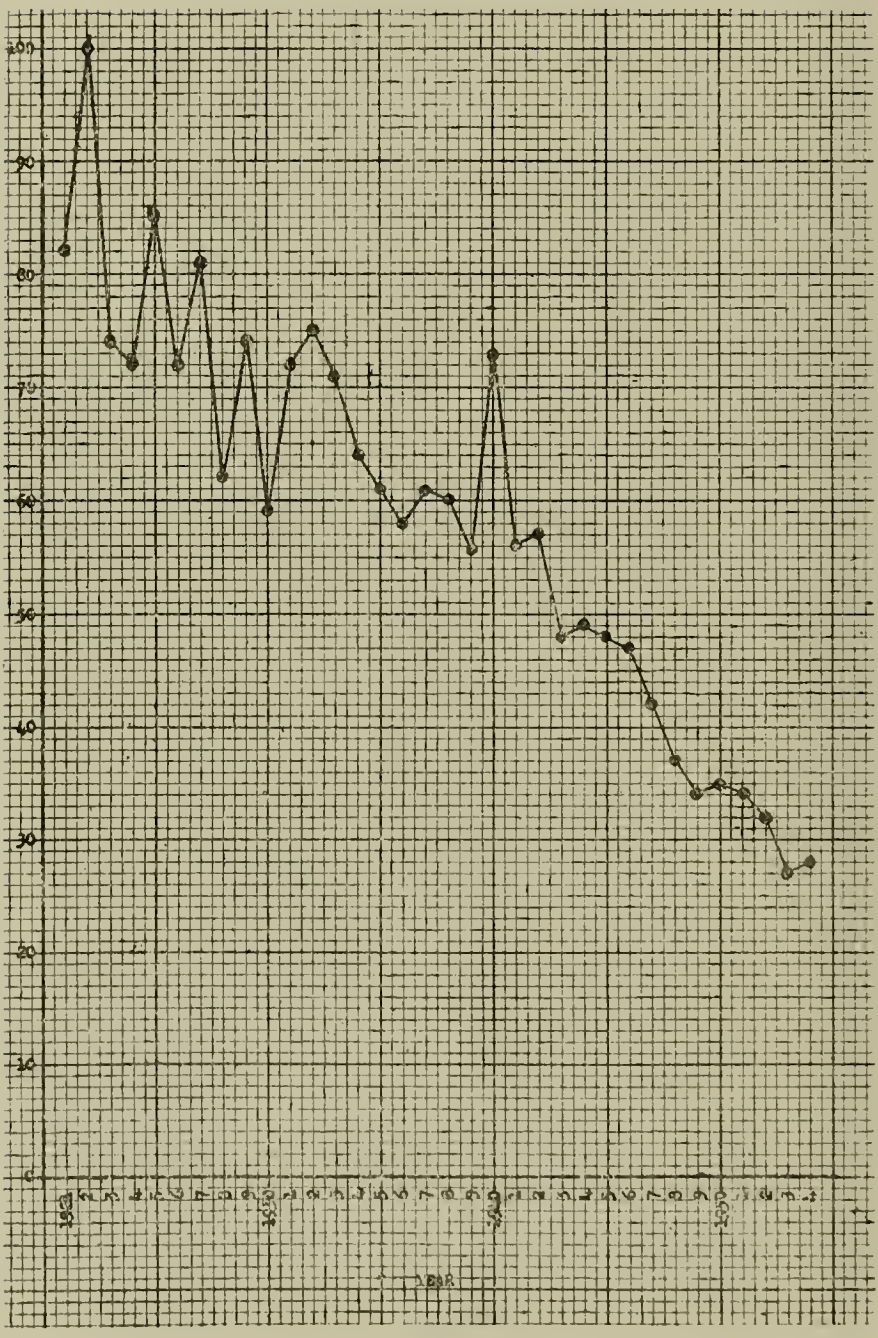
Administrative County of Cumberland



INFANT MORTALITY RATE

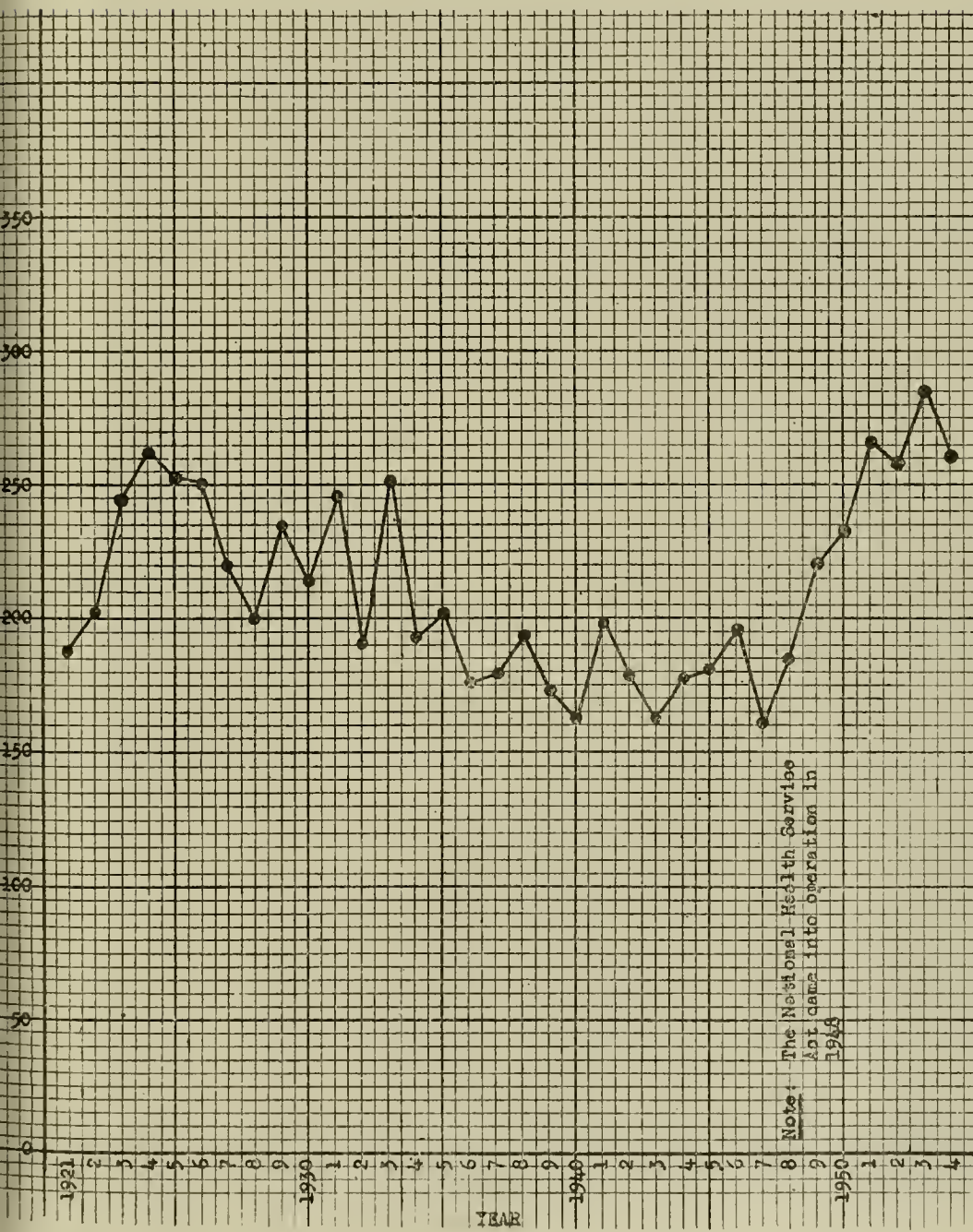
Death Rate Per 1,000 Registered Births

Administrative County of Cumberland



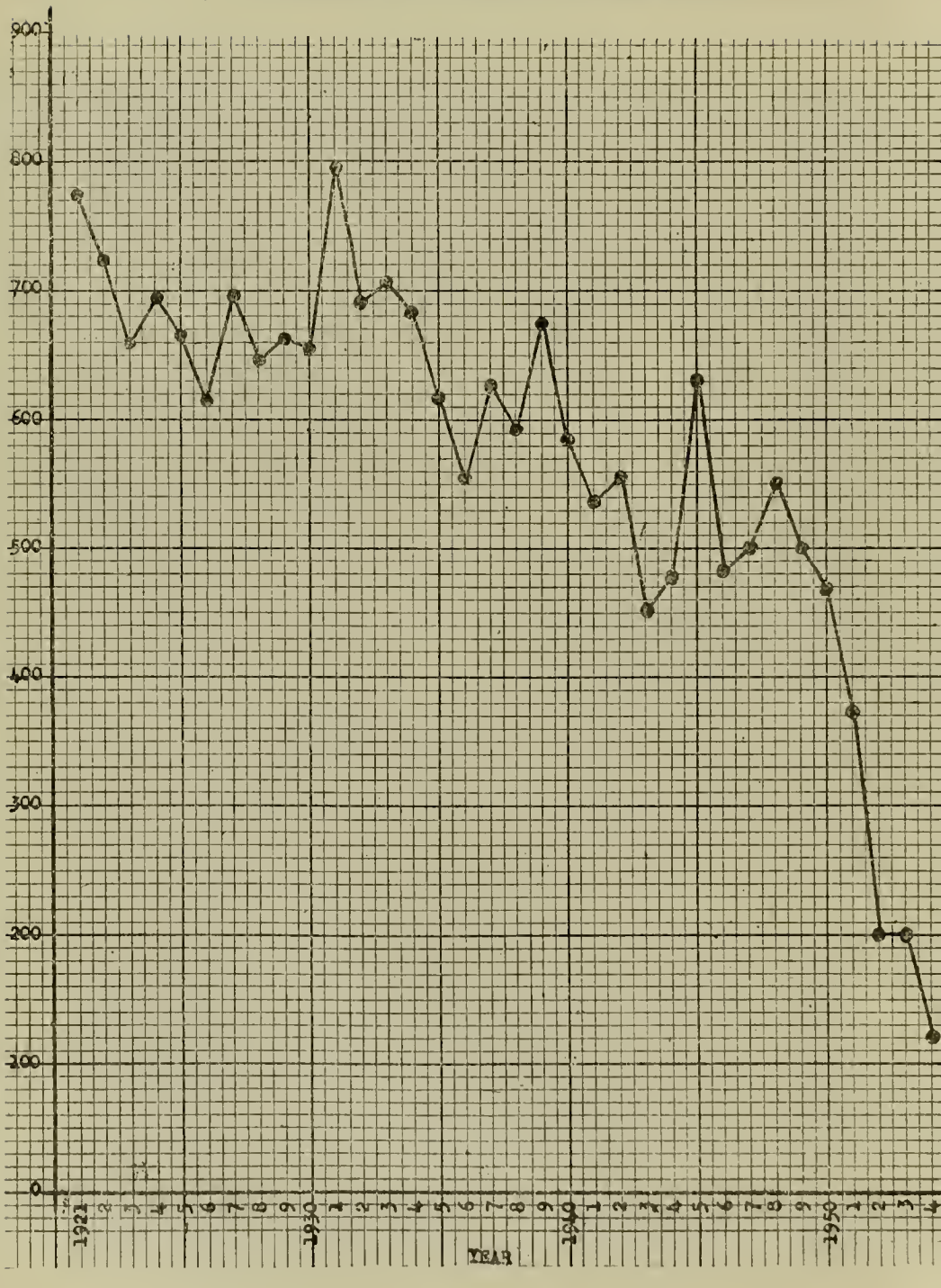
PULMONARY TUBERCULOSIS—NOTIFICATIONS

Administrative County of Cumberland



PULMONARY TUBERCULOSIS

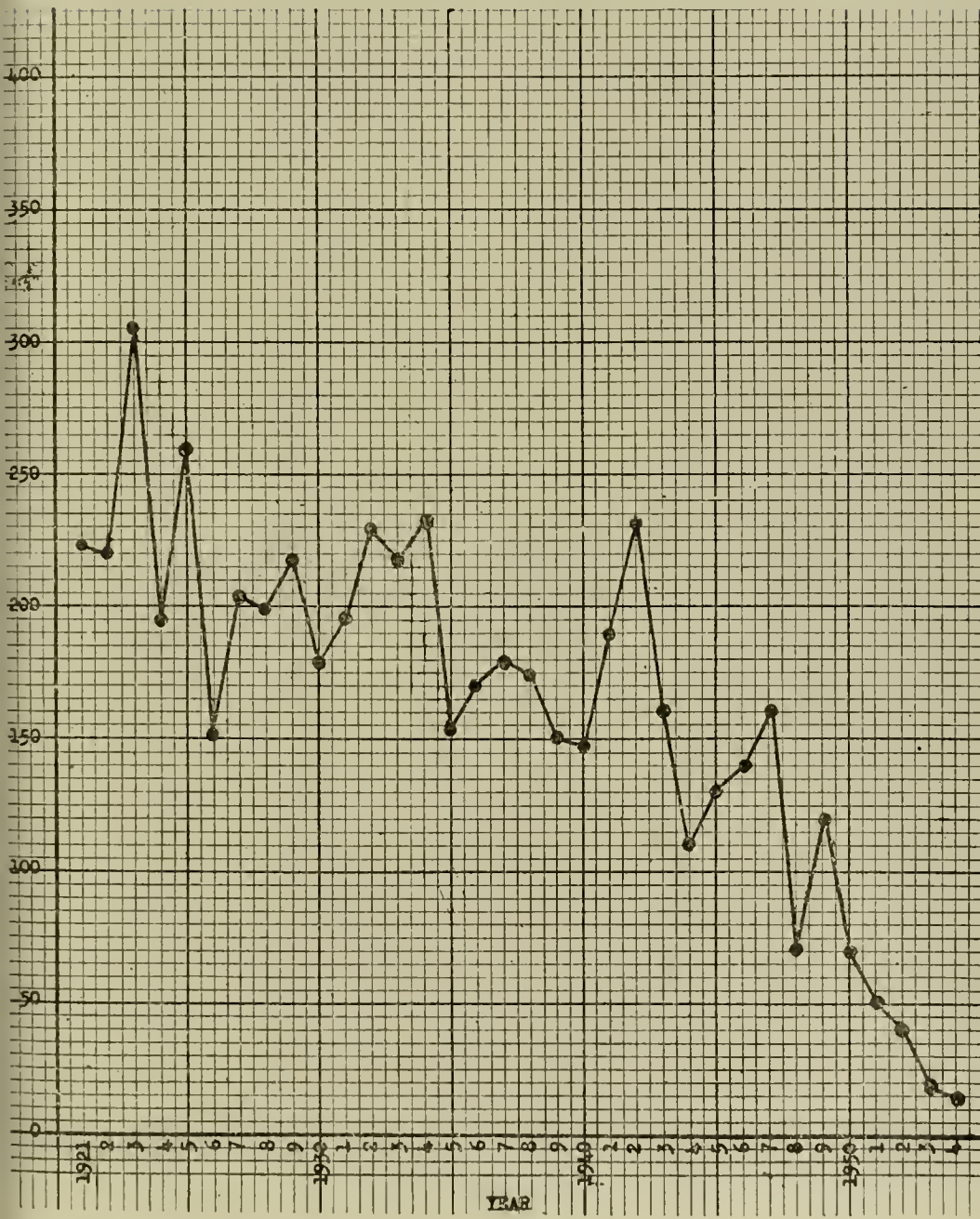
Death Rate Per Million Population
Administrative County of Cumberland



NON PULMONARY TUBERCULOSIS

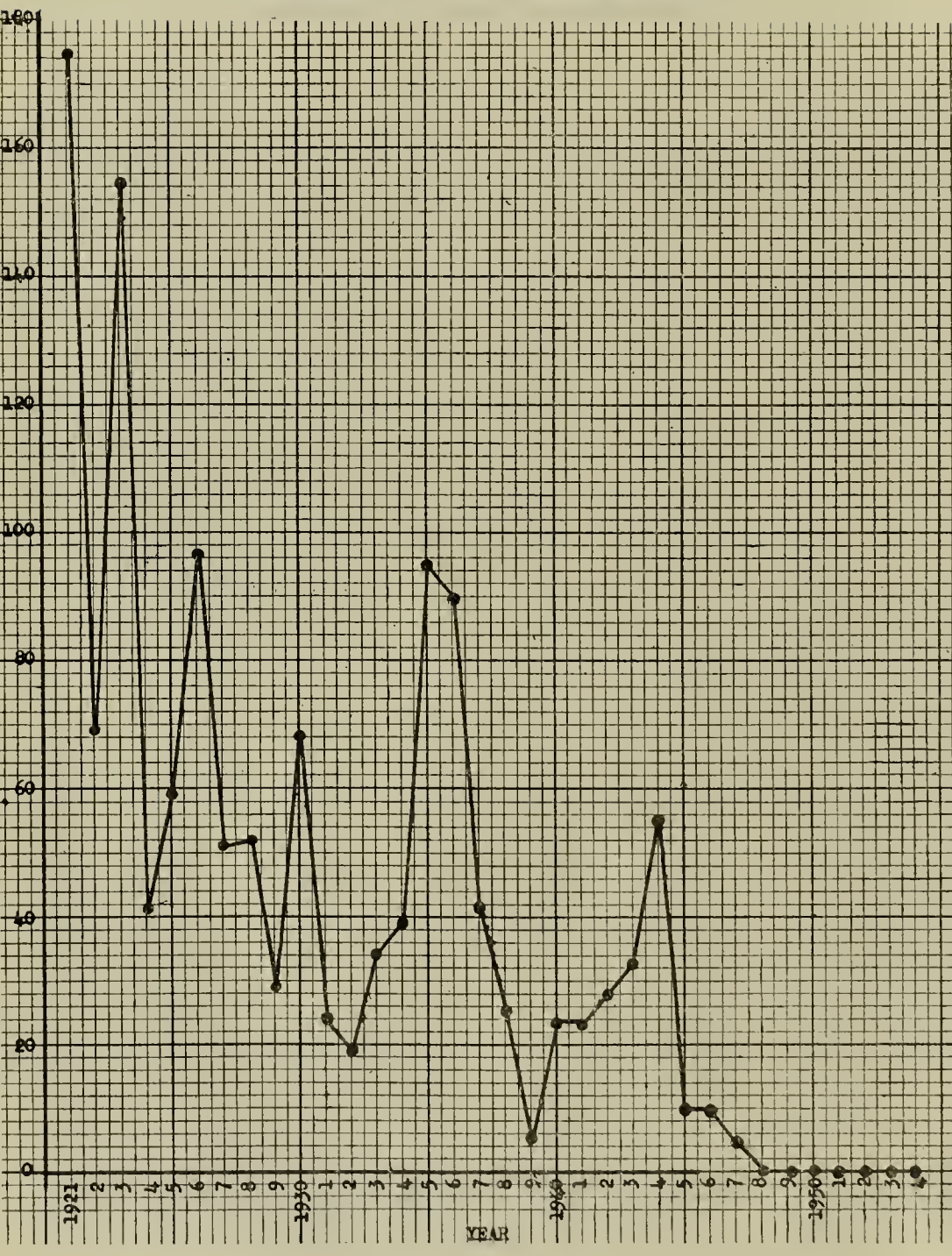
Death Rate Per Million Population

Administrative County of Cumberland



DIPHTHERIA

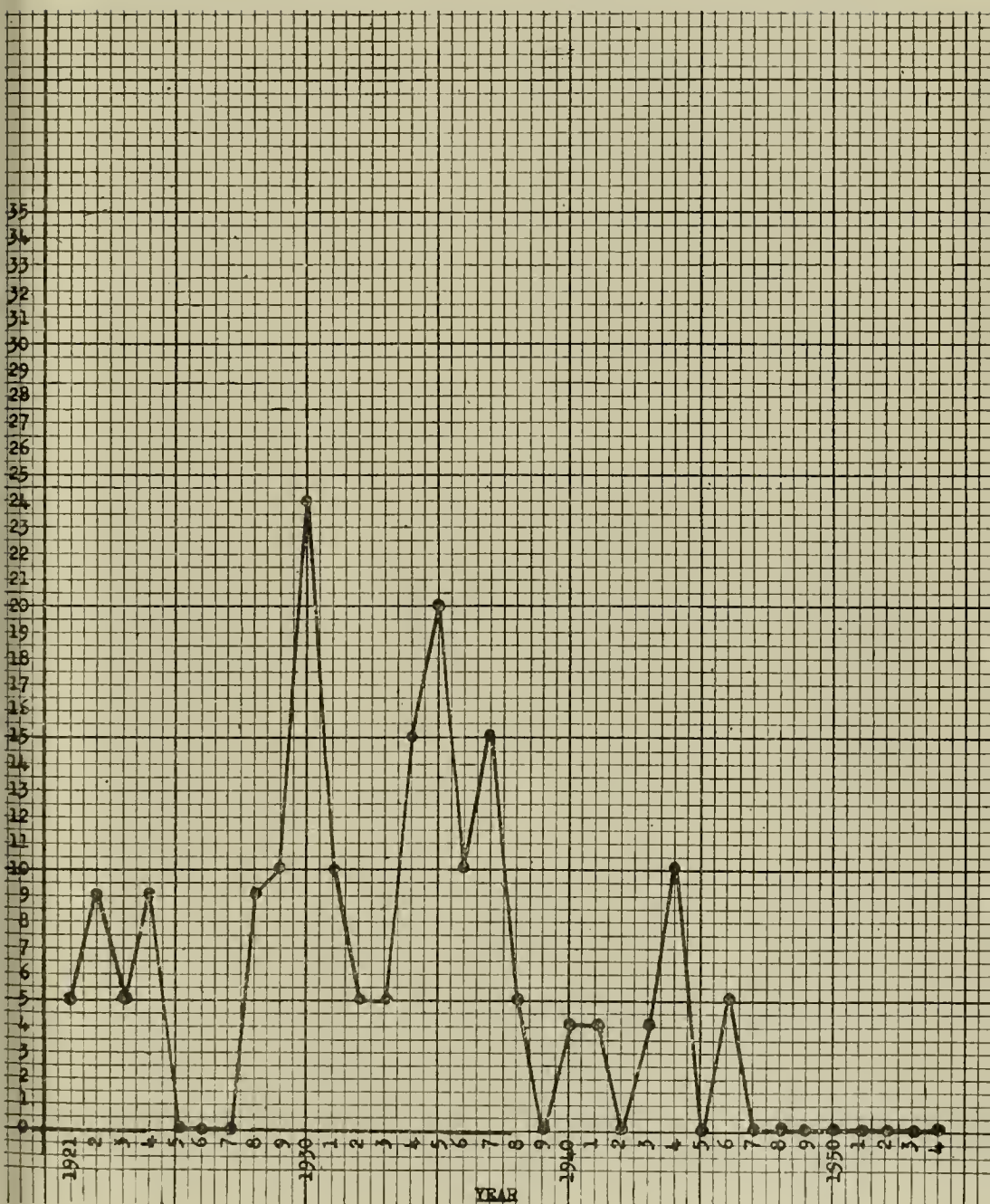
Death Rate Per Million Population
Administrative County of Cumberland



ENTERIC FEVER

Death Rate Per Million Population

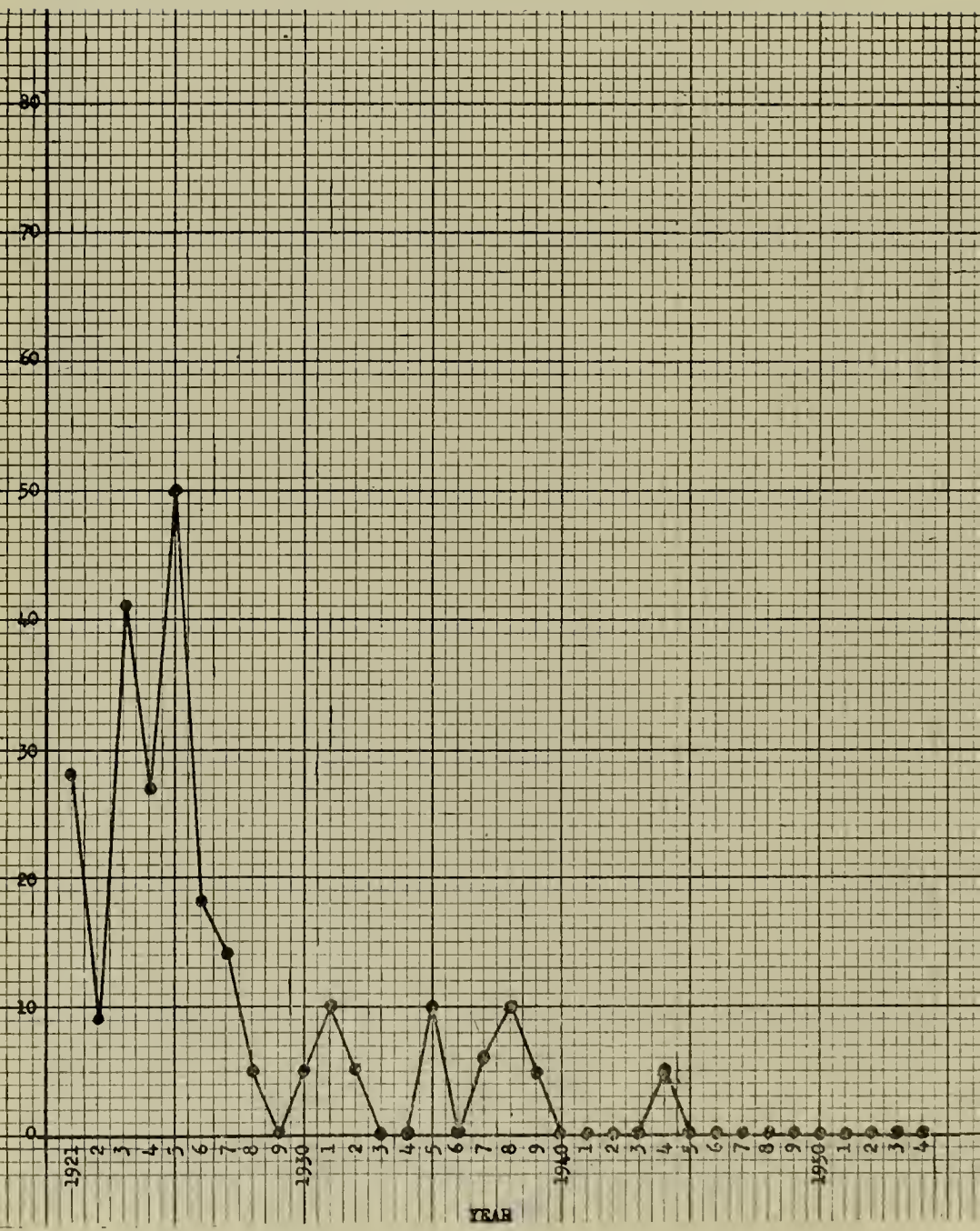
Administrative County of Cumberland



SCARLET FEVER

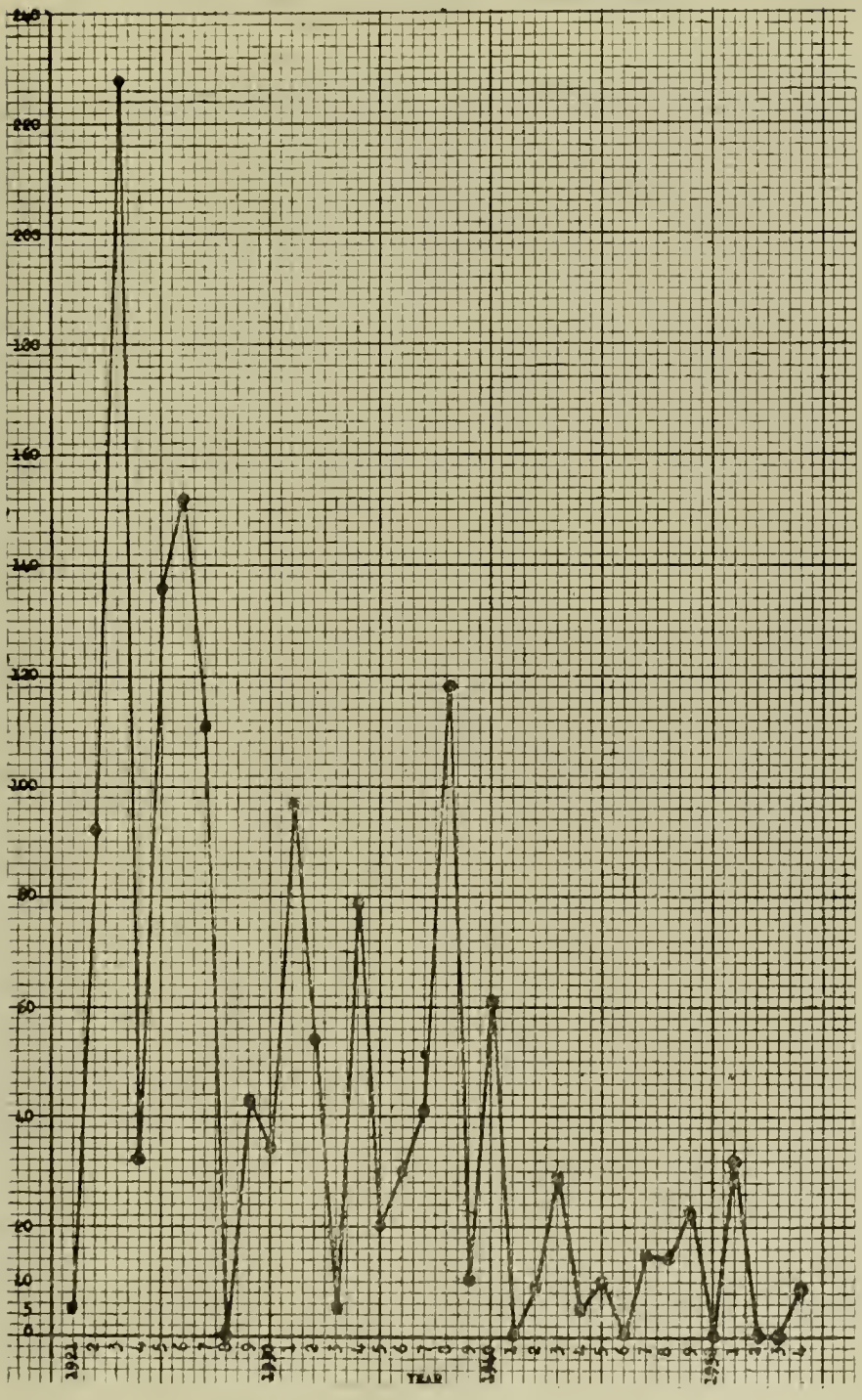
Death Rate Per Million Population

Administrative County of Cumberland



MEASLES

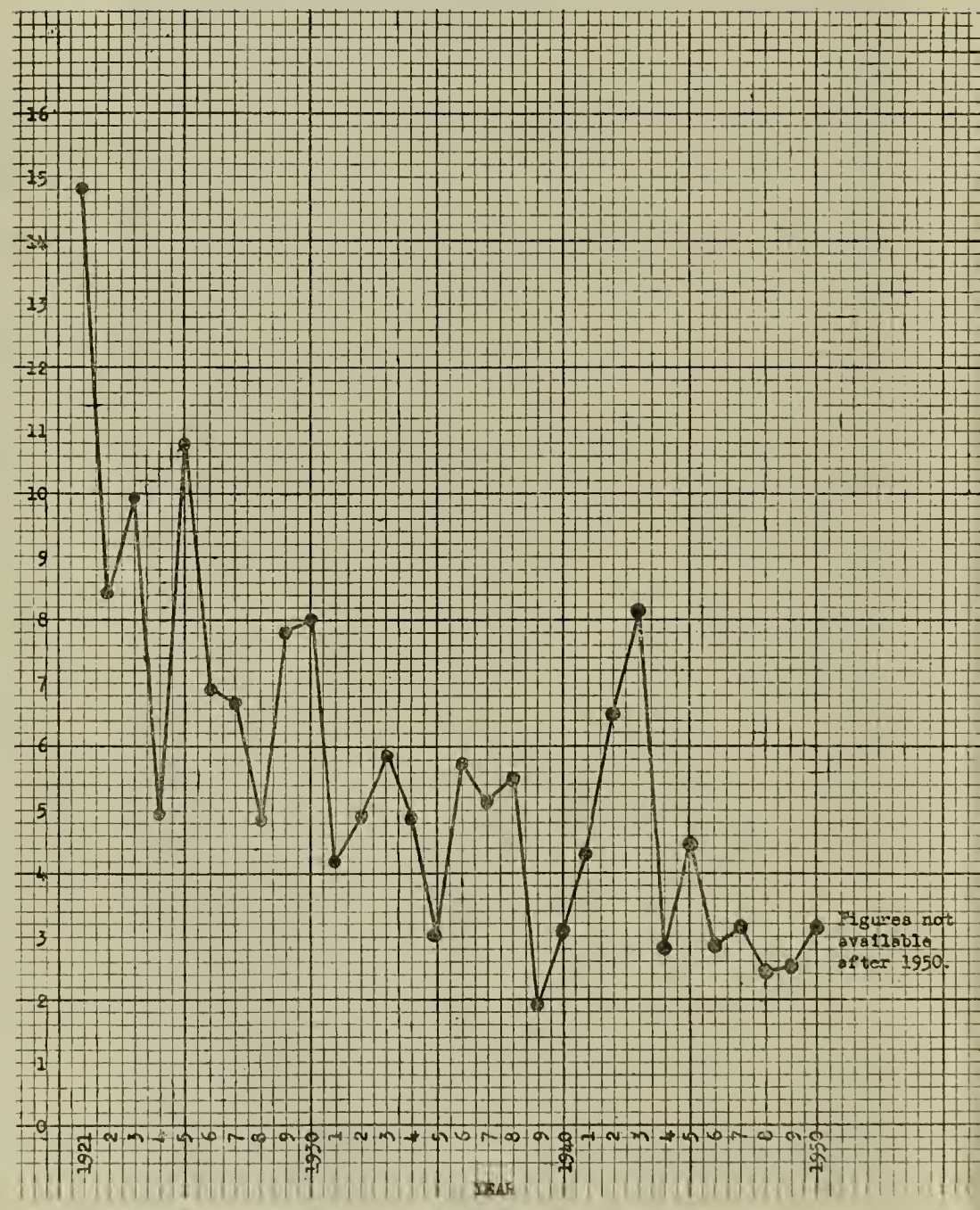
Death Rate Per Million Population
Administrative County of Cumberland



DIARRHOEA (Under 2 Years)

Death Rate Per 1,000 Registered Births

Administrative County of Cumberland



NATIONAL HEALTH SERVICE ACT, 1946

Part III

Section 21—Health Centres.

The Nursing Services.

Section 22—Care of Mothers and Young Children.

Section 23—Midwives Service.

Section 24—Health Visiting.

Section 25—Home Nursing.

Section 26—Vaccination and Immunisation.

Section 27—Ambulance Service.

Section 28—Prevention of Illness, Care and After-care.

Section 29—Home and Domestic Help.

Part V

Section 51—Mental Health Service.

In accordance with the wishes of the Ministry, lists are appended "A" of the committees which are concerned with matters of public health, and "B" of the medical, dental, nursing and other technical staff, and the senior officers dealing with administration.

A. LIST OF COMMITTEES CONCERNED WITH MATTERS OF PUBLIC HEALTH

HEALTH AND HOUSING COMMITTEE

Dickinson, R. F. (Chairman)
Cain, Mrs. E. G. (Vice Chairman)

Batey, Rev. H. T.
Bland, T. P.
Broadbent, C. W.
Douglas, J.
Herdman, J. F.
McCann, Rev. F. K.
McCarron, J. H.
McKeating, Mrs. B. O.
McPoland, Mrs. F.
Mitchell, J.
Nixon, W. G.
Powers, J. E.
Smith, Mrs. M.
Townsley, R.
Waddell, W.
Walsh, J.
Wilson, D. G.
Wright, T.
Young, T.
One Vacancy.

Ex-Officio members

Edmonds, C.
Gaskarth, F. G.
Roberts, C. H.

External members

Braithwaite, Dr. J.
Chalmers, Dr. R. W.
Court Brown, Mrs. J.
Curwen, Mrs. C. St. G.
Eves, A. J., M P.S.
Faulds, Dr. J. S.
Ferguson, Dr. T. T.
Fisher, Miss M. C.
Fletcher, Dr. A. F.
Graham, Miss E. R.
Hasell, Mrs. G.
Hodgson, Mrs. H. L.
James, Mrs. E. L.
Jolly, Dr. G. M.
McCowan, R. D.

HEALTH GENERAL PURPOSES SUB-COMMITTEE

External members

Court Brown, Mrs. J.
Curwen, Mrs. C. St. G.
Fisher, Miss M. C.

MENTAL HEALTH SUB-COMMITTEE

External members

Braithwaite, Dr. J.
Chalmers, Dr. R. W.
Curwen, Mrs. C. St. G.
Ferguson, Dr. T. T.

HEALTH (EASTERN) AREA SUB-COMMITTEE

External members

Court Brown, Mrs. J.
Eves, A. J., M.P.S.
Hodgson, Mrs. H. L.
James, Mrs. E. L.

District Council Representatives

Alston R.D.C. ... 1
Border R.D.C. ... 2
Keswick U.D.C. ... 1
Penrith R.D.C. ... 1
Penrith U.D.C. ... 1
Wigton R.D.C. ... 2

HEALTH (WESTERN) AREA SUB-COMMITTEE

External members

Chalmers, Dr. R. W.
Curwen, Mrs. C. St. G.
Ferguson, Dr. T. T.
Graham, Miss E. R.
McCowan, R. D.

District Council Representatives

Cockermouth R.D.C. 1
Cockermouth U.D.C. 1
Ennerdale R.D.C. ... 2
Maryport U.D.C. ... 1
Millom R.D.C. ... 1
Whitehaven B.C. ... 2
Workington B.C. ... 2

JOINT (HEALTH AND EDUCATION) SUB-COMMITTEE

Health Committee Representatives

Cain, Mrs. E. G.
Curwen Mrs. C. St. G.
Dickinson, R. F.
Douglas, J.
Roberts, C. H.
Waddell, W.

Education Committee Representatives

Clayton, Rev. F. C.
Edmonds, C.
Gilbertson, J. W.
Gorley, Mrs. G. B.
Wilson, Major F. G.

* AMBULANCE SERVICE SUB-COMMITTEE

* HEALTH CENTRES AND CLINICS SUB-COMMITTEE

* NURSING SUB-COMMITTEE

External members

Court Brown, Mrs. J.
Curwen, Mrs. C. St. G.
Fisher, Miss M. C.
Graham, Miss E. R.
Hasell, Mrs. G.
Hodgson, Mrs. H. L.
James, Mrs. E. L.

* WELFARE SUB-COMMITTEE

Broadbent, C. W.
Clayton, Rev. F. C.
Douglas, J.
Edmonds, C.
Gilbertson, J. W.
Kilbride, J.
MacInnes, Miss J. E.
McCarron, J. H.
McKeating, Mrs. B. O.
Smith, Mrs. M.
Young, T.

* The following are ex-officio members of these sub-committees:-

Cain, Mrs. E. G.
Dickinson, R. F.
Roberts, C. H.

SEWERAGE AND WATER SUPPLY SCHEMES

Bowness, W.
Coulthard, J.
Gasgarth, F. G.
Holliday, R.
Kilbride, J.
Kyle, W. C.
McCann, Rev. F. K.
Powers, J. E.
Teasdale, Mrs. G. R.
Wharton, J. W.
Wilson, Major F. G.

Ex-officio:-

Roberts, C. H.
Edmonds, C.

The Children's Committee are also concerned with public health matters in respect of the care and supervision of neglected, ill-treated or abandoned children.

B. STAFF EMPLOYED DURING 1954

MEDICAL OFFICERS

County Medical Officer—

Kenneth Fraser, M.D., F.R.S.E., D.P.H., D.T.M.	Administrative.

Deputy County Medical Officer—

W. H. P. Minto, M.D., D.P.H. (Commenced 26th April, 1954).	Administrative. and Clinical.

Medical Officers in Mixed Appointments—

John R. Hassan, M.B., Ch.B., D.R.C.O.G., Also Medical officer of Health, Alston R.D.C. (In general practice)	Clinical.
James L. Hunter, M.B., Ch.B., D.P.H. (Also Medical Officer of Health Workington Borough). (Senior Assistant County Medical Officer, West Cumberland).	Administrative. and Clinical.
Isaac S. Jones, M.R.C.S., L.R.C.P., D.P.H. Also Medical Officer of Health, Wigton R.D.C. and Penrith U.D.C.	Clinical.
Charles A. Mason, M.B., Ch.B., D.P.H., Also Medical Officer of Health, Cockermouth R.D.C., Cockermouth U.D.C., and Keswick U.D.C. (Resigned 27th July, 1954).	Clinical.
John Patterson, M.B., B.Ch., B.A.O., D.P.H., Also Medical Officer of Health, Cockermouth R.D.C., Cockermouth U.D.C., and Keswick U.D.C. (Commenced 1st December, 1954).	Clinical.
Ethel A. Perrott, M.D., B.S., D.P.H., Also Medical Officer of Health Millom R.D.C.	Clinical.
Kenmure J. Thomson, M.B., Ch.B. D.P.H. Also Medical Officer of Health Border R.D.C. and Penrith R.D.C.	Clinical.

Assistant County Medical Officers—

Whole-Time

James E. Gallagher, M.B., B.Ch., B.A.O., L.M., D.C.H., D.P.H.	Clinical.
Frederick V. Jacques, M.B., Ch.B., D.P.H., D.T.M. & H. (Died 18th March, 1954).	Clinical.
Gladys J. G. Lowe, M.R.C.S., L.R.C.P., (Resigned 26th April, 1954)	Clinical.
Agnes T. Harbison, M.B., B.Ch., B.A.O., D.P.H. (Commenced 1st November, 1954)	Clinical.

Note: "Clinical Duties" include school medical inspections, school clinics, and child welfare clinics.

DENTAL OFFICERS

Senior Dental Officer—

A. C. S. Martin, L.D.S.	Administrative, and Clinical.

Assistant Dental Officers—

I. R. C. Crabb, L.D.S.	Clinical.
Mrs. A. M. E. Ferguson, L.D.S. (Resigned 31st March, 1954)	
D. H. Hayes, L.D.S.	
Mrs. M. Hayes, B.D.S.	
F. H. Jacobs, L.D.S. (Commenced 15th June, 1954)	
D. C. Lamond, L.D.S.	
R. B. Neal, M.B.E., L.D.S.	
A. R. Peck, L D.S.	

ORTHOPAEDIC PHYSIOTHERAPISTS

Miss J. M. Morris, C.S.P., M.E.	Administrative, clinical and domiciliary visiting.
Miss B. M. W. Summerson, C.S.P., L.E.T. (Orthopaedic Nursing Certificate).	Clinical and domiciliary visiting.

SPEECH THERAPISTS

Miss D. Chapman, L.C.S.T.
Miss E. M. Rawle, L.C.S.T.

ORTHOPTISTS

Miss J. F. Maughan, D B.O.
(Resigned 4th June, 1954).
Miss M. F. Brown, D.B.O.
(Commenced 1st September, 1954).

MENTAL HEALTH

Consultant Psychiatrists—Part-Time

Seconded from Newcastle Regional Hospital Board
J. Braithwaite, M.B., Ch.B., D.P.M.
J. R. Stuart, M.B., Ch.B., D.P.M.
T. T. Ferguson, L.R.C.P., L.R.C.S.
L R.F.P.S.

Mental Health Officer—

N. Froggatt.

Psychiatric Social Workers—

Miss M. Lamb (Part-time seconded from Newcastle Regional Hospital Board)	Child Guidance.
Miss J. Simpson, B.A.	

Mental Health Workers —

Miss A. G. N. O'Regan.
Miss E. Hall.

ADMINISTRATIVE OFFICER

W. Butcher.

NURSING STAFF

Superintendent Nursing Officer—

Miss I. Mansbridge, S.R.N., S.C.M., Q.N., H.V. Cert.	Administrative. Also home help organiser.

Deputy Superintendent Nursing Officer—

Miss S. Keeler, S.R.N., S.C.M., Q.N., H.V. Cert.	Administrative. Also home help service.

Assistant Superintendent Nursing Officers—

Miss E. E. Jackson, S.R.N., S.C.M., Q.N., H.V. Cert.	Administrative.
Mrs. A. Steele, S.R.N., S.C.M., Q.N. H.V. Cert.	Also home help service

Health Visitors—

Miss M. Henderson, S.R.N., S.C.M., H.V. Cert.	Tuberculosis (Chest Centre) 50% domiciliary visiting 50%
Miss M. E. M. Gibson, S.R.N. S.C.M., H.V. Cert.	
Miss I. M. Alcock, S.R.N., S.C.M., H.V. Cert, (Commenced 21st June, 1954)	
Miss M. Armstrong, S.R.N., S.C.M., H.V. Cert. (Commenced 10th September, 1954)	
Miss A. Booth, S.R.N., S.C.M., H.V. Cert.	
Mrs. S. Bowe, S.R.N., S.C.M., H.V. Cert.	
Miss M. C. Burgess, S.R.N., S.C.M. H.V. Cert.	
Miss E. Crosby, S.R.N. S.C.M., H.V. Cert.	Domiciliary visiting, school health service maternity & child welfare, tuberculosis visiting, special enquiries.
Miss D. Dawson, S.R.N., S.C.M., H.V. Cert. (Commenced 1st July, 1954)	
Miss E. M. Garrett, S.R.N., S.C.M., H.V. Cert.	
Miss D. Green, S.R.N., S.C.M., H.V. Cert.	
Miss M. E. Harrison, S.R.N., S.C.M., H.V. Cert.	
Miss M. Hastings, S.R.N., S.C.M., H.V. Cert. (Resigned 30th April, 1954).	
Miss R. J. Hind. S.R.N., S.C.M., H.V. Cert.	
Miss M. Horn, S.R.N., S.C.M., H.V. Cert.	
Miss A. Hodgson, S.R.N., S.C.M., H.V. Cert.	
Miss F. Kendall, S.R.N., .S.C.M., H.V. Cert.	
Miss A. M. Little, S.R.N., S.C.M., H.V. Cert.	
Miss R. A. Lodge, S.R.N., S.C.M., H.V. Cert.	
Miss E. Mercer, S.R.N., S.C.M., H.V. Cert.	

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

The essential vital statistics for the year 1954 are as under:—

Population

	At 1951 Census.	Estimated by Registrar General Mid. 1954
Urban Districts ...	86,335	87,360
Rural Districts ...	131,118	129,240
Administrative County ...	217,453	216,600

Population of Sanitary Districts, 1954

Urban Districts		
Workington ...	28,930	
Whitehaven ...	25,240	
Maryport ...	12,620	
Penrith ...	10,520	
Cockermouth ...	5,280	
Keswick ...	4,770	
		87,360
Rural Districts		
Border ...	29,940	
Ennerdale ...	28,610	
Wigton ...	23,510	
Cockermouth ...	19,420	
Millom ...	13,960	
Penrith ...	11,490	
Alston ...	2,310	
		129,240
Total for Administrative County ...		216,600

Rateable Value and sum represented by a penny rate.

The rateable value of the County at 1st April, 1954, was £1,154,325. The estimated product of a penny rate was £4,470.

Extracts from vital statistics for the year 1954

LIVE BIRTHS

	Total Births	Males	Females
Legitimate ...	3,419	1,781	1,638
Illegitimate ...	134	73	61
Total ...	3,553	1,854	1,699

Birth Rate per 1,000 poplation 16.4
(England and Wales 15.2)

STILL BIRTHS

	Total Still-Births	Males	Females
Legitimate ...	101	60	41
Illegitimate ...	5	2	3
Total ...	106	62	44

Rate of Still-Births per 1,000 total births 29.8.
(England and Wales 24)

DEATHS

Total Deaths	Males	Females
2,567	1,373	1,194

Crude Death Rate per 1,000 population 11.9
(England and Wales 11.3)

DEATHS FROM DISEASES AND ACCIDENTS OF PREGNANCY AND CHILDBIRTH.

Pregnancy, Childbirth and abortion 4

Maternal Death Rate per 1,000 Total Births—1.13

DEATH RATE OF INFANTS UNDER ONE YEAR OF AGE.

All Infants per 1,000 Live Births 27.6
Legitimate Infants per 1,000 Legitimate Live Births 27.8
Illegitimate Infants per 1,000 Illegitimate Live Births 22.4

DEATHS FROM CANCER (ALL AGES) 354

DEATHS FROM MEASLES (ALL AGES) 2

DEATHS FROM WHOOPING COUGH (ALL AGES) 1

DEATHS FROM GASTRITIS, ENTERITIS AND DIARRHOEA (Under 1 Year) 5

The 3,553 live-births were distributed among the Urban and Rural Districts as follows:—

Births, 1954

Urban Districts	Total Births	Legitimate	Illegitimate	Birth Rate
Cockermouth	86	84	2	16.3
Keswick	44	44	—	9.2
Maryport	242	232	10	19.2
Penrith	188	176	12	17.9
Whitehaven	513	500	13	20.3
Workington	454	438	16	15.7
Aggregate of Urban Districts	1,527	1,474	53	17.5
Rural Districts.				
Alston	40	40	—	17.3
Border	428	408	20	14.3
Cockermouth	265	256	9	13.6
Ennerdale	503	488	15	17.6
Millom	228	212	16	16.3
Penrith	172	163	9	15.0
Wigton	390	378	12	16.6
Aggregate of Rural Districts	2,026	1,945	81	15.7

The 2,567 deaths were distributed among the Urban and Rural Districts as follows:—

Deaths 1954

Urban Districts	Total	Males	Females	Crude Death Rate
Cockermouth	72	37	35	13.6
Keswick	58	24	34	12.2
Maryport	146	63	83	11.6
Penrith	134	71	63	12.7
Whitehaven	249	135	114	9.9
Workington	338	192	146	11.7
Aggregate of Urban Districts	997	522	475	11.4
Rural Districts				
Alston	28	14	14	12.1
Border	432	223	209	14.4
Cockermouth	225	127	98	11.6
Ennerdale	336	195	141	11.7
Millom	144	74	70	10.3
Penrith	136	76	60	11.8
Wigton	269	142	127	11.4
Aggregate of Rural Districts	1,570	851	719	12.1

Causes of Death

	No. of Deaths.
Heart disease	996
Vascular lesions of nervous system	402
Cancer	354
Bronchitis	74
Tuberculosis — respiratory	26
Tuberculosis — other	3
Other circulatory diseases	95
Pneumonia	66
Influenza	21
Hyperplasia of prostate	15
Motor Vehicle accidents	25
All other accidents	79
Nephritis and Nephrosis	30
Congenital malformations	15
Gastritis, enteritis and diarrhoea	10
Diabetes	8
Other diseases of respiratory system	31
Ulcer, stomach and duodenum	15
Suicide, homicide and operations of war	17
Syphilitic disease	6
Meningococcal infections	6
Other infective and parasitic diseases	10
Leukaemia	4
Pregnancy, childbirth and abortion	4
Whooping cough	1
Measles	2
Other defined and ill-defined diseases	252

Infantile Mortality.

Of the 3,553 live births during the year, 98 infants died before reaching the age of 12 months. The infant death-rate per thousand live births is 27.6 compared with 27 for 1953. The figure for England and Wales is 25.5.

Causes of Death.

	No. of Deaths.
Whooping cough	1
Tuberculosis — respiratory	1
Influenza	1
Pneumonia	18
Bronchitis	2
Gastritis, enteritis and diarrhoea	5
Congenital malformations	13
Other defined and ill-defined diseases	47
Accidents	2
Other infective and parasitic disease	3
Other diseases of respiratory system	2
Meningococcal infections	2
Homicide	1
	98

Of the above 98 deaths among infants under the age of twelve months, 63 represented deaths of infants within the first 28 days, of which 32 were premature births. Reference is made elsewhere in this report to the question of prematurity.

The distribution of deaths by sanitary districts is shown in the following table:—

Urban Districts	No. of Infant Deaths	Rate
Cockermouth	1	11.6
Keswick	Nil	Nil
Maryport	12	49.3
Penrith	4	21.2
Whitehaven	10	19.5
Workington	11	24.2
Aggregate of Urban Districts	38	24.9
Rural Districts.		
Alston	Nil	Nil
Border	16	37.4
Cockermouth	6	22 6
Ennerdale	18	35.8
Millom	2	8.8
Penrith	3	17.4
Wigton	15	38.5
Aggregate of Rural Districts	60	29.6

1954 Rate for England and Wales ... 25.5
1954 Rate for Cumberland County ... 27.6

Health Education

To write a report on health education is perhaps more difficult than reporting on other sections of the Health Service. There are no statistics to offer and, except over a long period, it is impossible to assess the result in relation to all the work and effort expended. Last year the Expert Committee of the World Health Organisation published an illuminating report on the health education of the public. At the beginning of the report the committee stated that although health education is only one of the factors in improving health and social conditions, it is an indispensable factor. The report also stated that the aim of health education is to help people to achieve health by their own actions and efforts. In this latter respect health visitors and district nursing staff have the unique opportunty of educating and teaching the public during the course of their work each day, in the homes of the people they visit, in welfare clinics and nurses' surgeries, in schools and to various other organized groups in the community. Talks and lectures, discussion groups and symposia, with visual aids such as the flannelgraph, magnetic board, demonstration material and film-strips, are some of the methods used for group teaching. Such methods can be effective and are inexpensive.

During the past year members of the administrative, health visiting, and nursing staff have participated in health teaching programmes according to the needs and opportunities available in each area. Requests for lectures have been received from Women's Institutes, the Red Cross and St. John Ambulance Brigade and from other organizations, to all of which we have been able to send lecturers. Most of these lectures take place in the evenings. A film-strip apparatus and some film-strips were bought and have been well used, but a greater selection of film-strips are needed for showing to all sections of the public and perhaps to the older age groups of school children.

At the beginning of July the Central Council for Health Education held a three-day course for health visitors and other public health personnel on "The Theory and Practice of Health Education." This course took place in Carlisle in conjunction with the staff of the City of Carlisle Health Department and was well

attended. A similar course has been arranged to be held this year.

During the week beginning July 19th the health visitors and midwives produced a health exhibition which was open to the public for two days at Workington and two days at Whitehaven. The exhibition depicted the work of the health department and showed various aspects of health teaching such as nutrition, clean food, proper clothing, sleep, the prevention of illness, etc. The County Road Safety Officer (Mr. J. E. Armstrong) showed films during the afternoon. There was not a great response from the public, but arrangements were made for local school children to attend.

Up to the present time we have tried various methods of health education, collected together a variety of suitable equipment and those actually interested and engaged in this work have had the opportunity of further education in the art of teaching. There is still much scope in the county, however, for developing this aspect of the work of a health department.

SECTION 21

Health Centres

No change has taken place in this matter during the year.

Clinics

During the year a much needed new clinic was opened at Millom. This clinic provides a flat for the health visitor for the district—an innovation in this county. At the time of writing a new clinic at Penrith is approaching completion replacing a converted private dwelling house which was the first clinic of any kind to be opened by the County Council in the county and which has served its purpose fairly well for over forty years, so it owes us nothing.

At the time of writing plans for a clinic in the Valley Estate at Whitehaven have been approved by the Ministry and building should shortly start. Plans have been prepared for a new clinic and a new occupation centre at Wigton, and plans are in course of preparafor new clinic buildings with a certain amount of attached office accommodation at the Flatt Walks site at Whitehaven which has been acquired from the Town Council. The new clinic buildings at Flatt Walks when in occupation will represent by far the most important and the most needed development of our clinic buildings in the county because they will replace the hopelessly out of date premises in Sandhills Lane and at 10 Scotch Street. The three-storied clinic building in Sandhills Lane which we inherited deals with an average attendance of over 20,000 a year. The building has no pram shelter and hardly any worth while amenities at all, and how the staff have carried on there over the years coping with the numbers they have done is difficult to understand.

THE NURSING SERVICES

Section 22—Care of Mothers and Young Children.

Section 23—Midwives Service.

Section 24—Health Visiting.

Section 25—Home Nursing.

The broad principles governing the administration of our nursing and midwifery services, arising out of the Midwives Act 1936 and the National Health Service Act 1946 have been analysed in great detail in previous reports. No material change has taken place, and therefore what follows in this general section merely brings the position up to date.

May I remind you that the target of our nursing services is to have a state registered nurse with the certificate of the Central Midwives Board in each district, except for a few districts where, there being whole-time midwives, some of the nurses are exclusively concerned with general nursing.

The target also is that each nurse shall be decently housed, and, with the exception of one or two areas where this is not necessary, should be provided with a car, and that all nurses should be on the telephone.

We are, of course, affiliated to the Queen's Institute of District Nursing, and I think it is essential that every district nurse before taking up a post in the field should have undergone a period of district training. This has not yet been made compulsory by the Ministry, but I think it is generally accepted that it may shortly be so as a working party is now considering this very question.

At the time of writing we employ 54 Queen's or State Registered Nurses, 27 State Enrolled Assistant Nurses, all with the exception of one being State Certified Midwives. At this time last year there were 49 Queen's or State Registered Nurses in our employment, and therefore we have made quite a step during the year towards our ultimate target. Of the 49 Queen's or State Registered Nurses doing district work in the county, 9 hold the Health Visitor's Certificate—this represents an increase of 6 in the last 2 years. The

remainder of the district nurses, 38, all working in rural areas, undertake health visiting in their respective districts under a dispensation granted yearly by the Ministry. At the time of writing we have two nurses studying for the Health Visitor's Certificate under the County Council scholarship scheme. During the year, 6 nurses undertook the district training course of the Queen's Institute, and at the end of the year 2 others were taking this course.

At the recent congress of the Royal Sanitary Institute, one session was devoted to the work of health visitors and it was quite apparent that the general feeling was that the sphere of their operations in public health departments should be considerably extended. This of course is in keeping with paragraph 30 of circular 118 issued by the Ministry when the National Health Service Act came into operation. This paragraph says that it is the duty of local health authorities to provide a complete health visitors service " for the purpose of giving advice as to the care of persons suffering from illness, including mental illness, and any injury or disability requiring medical or dental treatment or nursing, to expectant and nursing mothers and to mothers and others with the care of young children. After the appointed day she will be concerned with the health of the household as a whole, including the preservation of health and precautions against the spread of infection, and will have an increasingly important part to play in health education."

It seems to me clear that a group of persons with these responsibilities and duties must be hand picked and it does not seem to me that the mere application of a nurse for scholarship to take the health visitor's training course of itself provides an adequate approach to selection for future health visitors. We take some care about this in this county.

I think too, that in addition to the routine nursing and midwifery training, the duties outlined in the Ministry's circular must imply two other things,

(a) A period of training of not less than 12 months in social service, and

(b) A close and intimate knowledge of the services which health departments can and do provide and the channel of approach to these benefits.

I also think that it is not by any means generally appreciated that a nurse undertaking the health visitor's training, even with the grant of a scholarship of say £250 for the nine months training, may well be suffering substantial loss. Many experienced nurses may be receiving salaries of anything from £525 to £545 per annum, and the nurse who goes away to undertake her Queen's district training and to obtain the health visitor's certificate receives on return not more than £10 per annum in respect of each of these additional qualifications, and may in fact, in certain cases, receive nothing at all, in spite of the fact that she has experienced a substantial loss of salary during the period in question.

We hear a lot these days about the importance of the differential in the matter of salary and wage scales — I think it is abundantly clear that the addition of £10 to the salary of the nurse in respect of each of the qualifications I have referred to, provides a most inadequate differential, and in fact as I have said, in some cases may provide no differential at all. It is therefore surprising that so many nurses are willing to take this post-graduate training—clearly not from the motives of financial gain, but with the object of increasing their efficiency.

The housing position has improved quite substantially during the year. Eight houses which were under construction at the time of last year's report are now in occupation at Parton, Bothel, Frizington, Caldbeck, Braithwaite, Fletchertown, Cleator Moor, and Abbeytown. During the current year, three and possibly four more houses will be built by the County Council at Crosby on Eden, Dalston, Threlkeld and possibly Whitehaven, and two being built by district councils will come into occupation at Crosby, near Maryport, and Egremont. At the end of 1954 the housing position as affecting district nurse midwives was as follows :—

Houses rented by the County Council	26
Houses bought by the County Council, previously owned by district nursing associations ...	9
Houses built by the County Council	9
	44

In addition, the newly constructed clinic at Millom which came into occupation during the year had provision for a flat for a health visitor, and this policy will

be followed at Penrith where the new clinic is approaching completion, and in due course we hope at Wigton. Of the remaining district nurses, two are living in rooms, and the remainder of the nurses are living in houses owned or rented by themselves. All the above means that we are at reasonable speed proceeding to our goal of having all our district nurses satisfactorily housed. We would be glad to arrange for any members of the council who are interested to visit these new nurses' houses in their respective districts. As expected, we have found that the provision of satisfactory housing accommodation has been an important factor in attracting new nurses with appropriate qualifications and experience to our service when vacancies occur.

In the matter of transport the County Council now own 70 cars for all types of nurses and 24 nurses of one type or another own their own cars. There are only two self-contained nursing districts without cars (Brampton and Flimby) and in Whitehaven two district nurses on temporary engagement are without cars. In Cockermouth the two district nurses share a car and the same applies to Millom, although authority has just been given to provide a new car of the three-wheeler type for this district.

The health visitors as a group are not so well provided with transport as the other nurses, but they do not of course have to deal with emergency calls; nevertheless if the three wheeler type at Millom proves successful, we may well I think extend the provision of cars of this type for use by health visitors. In the matter of replacements, our general policy is that we purchase 8 new cars a year, which is proving barely sufficient to meet the position as regards replacements, and I feel that we ought always to have one or two cars which have been put off the road in reserve to cater for inevitable breakdowns.

At the time of writing two nursing districts are vacant, but on past experience we have reasonably good expectations of filling these vacancies. The one factor, I must emphasise again, which has proved important is the provision of adequate housing accommodation.

The Superintendent Nursing Officer or her assistants paid 205 routine visits of inspection and 642 special visits of one kind or another during the year.

We continue to co-operate with the Bolton Technical College Health Visitor's course, and have now established a similar link with Gateshead District Nursing Association in the matter of giving nurses undertaking post-graduate training of one kind or another, experience in a rural area. Student nurses to the number of some 35 have been out on the district with some of our district nurses from the training schools at the Cumberland Infirmary and Whitehaven and Workington hospitals. This arises out of the new syllabus of the General Nursing Council which requires that nurses in training should have some opportunity of experience in the social aspects of hospital and nursing work generally. In this connection, lectures have been given by the Superintendent Nursing Officer and her deputy to nurses in training at each of these hospitals.

We continue to co-operate with the West Cumberland Hospital Management Committee in providing domiciliary training in midwifery for students undertaking Part II of the Midwifery Training Regulations. During the year under review we actually have had 9 such pupils working in the district.

SECTION 22

Care of Mothers and Young Children

The statistics for the year which follow are set out in accordance with the instructions of the Ministry.

The figures for the child welfare centres set out in the table show in practically every item a substantial fall from the previous year. For example, the number of children under one year of age who attended a child welfare centre for the first time during the year fell from 1,643 in the previous year to 1,347 in 1954. The total attendances of all ages (i.e. 1—5 years) fell from 15,104 in the previous year to 12,794 in 1954.

CHILD WELFARE CENTRES

No. of centres provided at end of year.	No. of Child Welfare Sessions now held per month.	No. of children who first attended a centre of this Local Health Authority during the year, and who at their first attendance were under 1 year of age	Number of children who attended during the year and who were born in			Total number of children who attended during the year.	Number of attendances during the year made by children who at the date of attendance were:			Total Attendances during the year.
			1954	1953	1952-49		Under 1 year	1 but Under 2	2 but Under 5	
15	65	1.347	933	1.027	1,181	3,141	8,897	1.981	1,916	12,794

Still Births

As the preliminary figures for 1954 began to filter in from various sources, it appeared likely that the total number of stillbirths for the county for 1954 would exceed substantially the figure for 1953. Actually the final figure of 106, although it has passed the 100 mark is not a great increase on last year, but stillbirths and births ot premature infants who died within the first 28 days amounted during 1954 to 138, which is of course a substantial figure.

Preliminary figures for the maternity unit at Workington Infirmary appeared to show a substantial increase in stillbirths at that hospital, and I therefore got in communication with the consultant obstetrician to ask whether anything we could do as a supervising authority from the domiciliary midwifery angle would be of any value in bringing about a reduction of the stillbirth figures. The final figure for Workington Infirmary showed that the preliminary estimate was much too high, and the final figure represented a very small, if any, increase on the previous year.

Nevertheless from the investigations of the consultant obstetrician analysing the 22 stillbirths which actually occurred at Workington Infirmary during the year, an interesting picture emerges. The analysis shows that in no less than 13 of the 22 stillbirths during the year the cause of death was malformation of the foetus or decomposition of the foetus in utero. Actually 6 anencephalic births occurred, that is to say children born without heads. This I feel must be an abnormally high proportion in such a small total as 22.

During the year, 49 cases of hypertension, toxaemia, and/or eclampsia were dealt with, 64 Caesarean sections and 42 forceps deliveries were performed.

It is gratifying to know that out of this substantial number of difficult deliveries for one reason or another, not a single stillbirth was attributed to complications in labour.

Premature Infants

A premature infant is a child whose weight at birth is 5½ lbs. or less. Actually the smallest child born prematurely during the year weighed 2 lbs. 4 ozs. This child, born in Maryport Cottage Hospital, survived.

Weight at Birth.	PREMATURE LIVE BIRTHS																PREMATURE STILL-BIRTHS		
	*Born in Hospital			Born at home and nursed entirely at home.			Born at home and transferred to hospital on or before 28th day			Born in nursing home and nursed entirely there.			Born in nursing home and transferred to hospital on or before 28th day.			Born in hospital	Born at home.	Born in nursing home.
	Total	Died within 24 hours of birth.	Survived 28 days.	Total	Died within 24 hours of birth.	Survived 28 days.	Total	Died within 24 hours of birth.	Survived 28 days.	Total	Died within 24 hours of birth.	Survived 28 days.	Total	Died within 24 hours of birth.	Survived 28 days.			
(a) 3 lb. 4 oz. or less (1,500 gms. or less) ...	20	7	6	1	—	—	1	1	—	1	—	1	—	—	—	9	4	—
(b) Over 3 lb. 4 oz. up to and including 4 lb. 6 oz. (1,500—2,000 gms.) ...	31	3	26	2	—	2	6	—	6	1	—	1	—	—	—	17	3	—
(c) Over 4 lb. 6 oz. up to and including 4 lb 15 oz. (2,000—2,250 gms.) ...	41	2	34	4	1	3	5	—	5	1	—	1	—	—	—	4	1	—
(d) Over 4 lb. 15 oz., up to and including 5 lb. 8 oz. (2,250—2,500 gms.) ...	65	1	62	28	—	28	1	—	1	1	—	1	—	—	—	4	3	—
TOTALS	157	13	128	35	1	33	13	1	12	4	—	4	—	—	—	34	11	—

*The group under this heading includes cases born in one hospital and transferred to another.

Statistics with regard to prematurity are shown in the preceding table. It will be seen that 209 children were born prematurely, 157 in hospital, 48 at home, of whom 13 were transferred to hospital; the remainder (4) were born and nursed in nursing homes. Of the 209 premature births, 32 infants died within 28 days. Apart from the foregoing figures, 45 premature still-births occurred during the year.

The above figures more than justify the steps taken during the year to equip certain of our ambulances with Sorrento cots and Queen Charlotte oxygen tents, and for the other steps taken in conjunction with the hospitals to safeguard to the limit of practicability the lives of children born prematurely. These steps are discussed in detail in last year's report and need not again be referred to.

It is a curious fact that out of 157 children born in hospital, 29 died within 28 days of birth, whereas out of 35 children born prematurely at home, only 2 died within the same period. It has of course to be remembered that practically all the very small prematures are transferred to hospital, and therefore the figures are not comparing like with like.

It is interesting to note that the figures relative to prematurity are almost identically the same as those for 1953 as follows:-

	1953	1954
Total of children born prematurely ...	213	209
Died within 28 days	32	32
Premature still-births	45	45

These figures almost look as if we had arrived at a static position in this matter.

The following table shows the extent to which practitioners were concerned in the ante-natal examination of expectant mothers and in post-natal examinations in cases booked as midwives' cases. In a very large number of these cases our midwives were present at the examinations. This co-operation is, I am sure, valued both by the practitioners and the midwives.

Examinations at practitioners' surgeries ...	653
Examinations at patients' homes	109
Examinations by practitioners at clinics ...	148
Re-examinations	1,193
Total ...	2,108

Findings at examinations—Normal	710
Abnormal ...	205
Recommended for hospital on account of home conditions	90
Recommended for hospital on account of patient's condition	36
Recommended to be seen by specialist ...	23
Post natal examinations	201

The above table includes ante-natal and post-natal examinations at the County Council clinics at Maryport, Workington, Egremont and Cleator Moor, where the local practitioners use the facilities which we have been very glad to place at their disposal. I would venture to hope that when the new clinic premises are available at Penrith, Wigton, and Flatt Walk, Whitehaven, this use by medical practitioners of our clinic facilities for ante-natal examinations may be substantially expanded.

The table deals only with domiciliary examinations. In addition, of course, a very large amount of ante-natal and post-natal work is undertaken at the hospital clinics by specialists attached to these clinics. In practice we send quite a substantial number of cases, with the approval of the practitioners, for ante-natal examination and advice to the consultants attached to the hospitals concerned.

The following statistics supplied by the Hospital Management Committees are of interest:-

Hospital ante-natal cases		Patients admitted for ante-natal treatment	Patients delivered in hospital	Children born in hospital	No. of maternal deaths in hospital	No of infants born in hospital died before discharge
Patients	Attendances					
			EAST CUMBERLAND			
980	2,966	100	879	895	2	17
			WEST CUMBERLAND			
1,226	7,961	291	1,060	1,080	1	21
2,206	10,927	391	1,939	1,975	3	38

The above table excludes confinements in nursing homes, whether in Carlisle or in the administrative county. It is interesting to note that the number of patients delivered in hospital at 1939 is almost identical with the figure for the previous year and the figures for hospital deliveries in East and West Cumberland

hospitals individually are also almost identical with the previous year. This seems to make it clear that the hospitals are working at saturation point. One point of interest emerges from the above table. That is that after allowing for the deaths of premature infants which have previously been referred to there were only 24 infant deaths in hospital out of 1,975 births. This gives a mortality rate of 1.2 per cent, or if deaths of premature infants born in hospital or transferred to hospital after birth are included gives a rate of 1.9 per cent. This is slightly above the National figure for 1954 which is 1.77 per cent, but having regard to the fact that 170 infants were born prematurely in hospital or were transferred to hospital on account of their condition these figures cannot, I think, be regarded as other than satisfactory.

To complete the above figures of hospital deliveries, mention should be made of the confinements which occurred during the year in respect of unmarried mothers as follows:-

St. Monica's Maternity Home, Kendal	15
Brettargh Holt Maternity Home, Kendal ...	6

At this point I ought to refer to our indebtedness to the authorities of Coledale Hall, Carlisle, for the help they give us in providing ante-natal accommodation for unmarried mothers, and also in a number of cases in helping in the matter of rehabilitation. This home, owing to the shortage of staff, had to close at the end of October 1954, but I am glad to be able to report that it is likely to re-open in the early summer of 1955.

SECTION 23

Midwives Service

During the year 135 midwives notified their intention to practise. These notifications include 9 whole-time district midwives, 77 district nurse midwives, 45 midwives working in the maternity departments of hospitals in the administrative county, two midwives acting independently, and two maternity nurses.

The number of domiciliary confinements undertaken during the year was 1,448. This is appreciably lower than for 1953 and reflects I suppose, a general fall in the birth rate. The total figure is made up as under:-

Cases in which a doctor was booked and was present at the confinement	312
Cases in which a doctor was booked but was not present at the confinement	487
Cases in which a doctor was not booked ...	649
	1,448

As a final point, the following short table may be interesting:-

Domiciliary Confinements

	Cases booked by doctors.	Cases not booked by doctors.	Total.	
East Cumberland ...	264	50	314	
West Cumberland ...	535	599	1,134	
				1,448

The progressive fall in the number of domiciliary confinements attended each year is, as has been noted in previous reports, not regarded with any enthusiasm by the midwives. I think it is true to say that apart from the whole-time midwives, the average district nurse midwife looks upon domiciliary midwifery as one of the most interesting aspects of her job, and the plain fact is that in many districts the district nurse may only attend a handful of confinements each year.

The number of patients delivered in hospital remains almost identical with the figure for the previous year, but even so this represents great pressure on hospital beds and in fact during the year some 840 mothers, and probably a good many more, were discharged from maternity units before the fourteenth day of the confinement.

Some years ago we instituted, in consultation with the consultant obstetricians, a scheme whereby in order to enable the maternity departments to utilise to the best advantage the available maternity beds, our midwives submited information which was transmitted to the obstetricians regarding the social and home conditions of women who desired hospital confinement on other than clinical grounds. At one time the volume of this work was considerable but now this, which we

would have thought was a really useful service to the hospitals, seems to be on the way out, and we are seldom asked for a report on domestic conditions which involves such matters as overcrowding, isolation, lack of water supply, etc.

The following short table shows the position in respect of ante-natal and post-natal visits by midwives covering midwifery and maternity:-

Home visits	11,902
Attendances at nurses' clinics	5,134
Total ...	17,036

During the year midwives sent for medical help in domiciliary cases on 362 occasions.

The Rh. Factor and Wassermann Testing

In my last annual report I reprinted a copy of a letter issued to all practitioners in the county, signed by the Senior Consultant Obstetrician, the Consultant Venereologist, and Director of the Cumberland Pathological Laboratory, and myself, seeking the co-operation of practitioners in the taking of blood specimens from expectant mothers not being confined in hospital. The object of taking these blood samples is twofold. In the first place it enables blood grouping to be undertaken, and it provides information as to whether the blood of the mother is Rhesus positive or Rhesus negative, and if negative, whether antibodies are present. In the second place it ascertains the cases, fortunately small, in which the mother has acquired or has inherited syphilis. Both these points, as is well known, are of supreme importance to the mother, to the unborn child, and indeed to the whole household.

In 1953 the number of blood samples submitted for test amounted to 509, which represented less than one-third of the domiciliary confinements. It is very satisfactory to report that for 1954 the figure rose to 722 specimens, which represents almost exactly 1 in 2 of the domiciliary confinements during the year. We are very grateful to the practitioners who have co-operated, but it is impossible to overlook the fact that from more than half of the practices in the county no blood specimens from ante-natal women were submitted.

The first important thing in this matter is to locate the expectant mothers whose blood is Rhesus negative with antibodies. According to our records 3 such reports arose during the year from the 722 specimens submitted in respect of domiciliary confinements. I believe that the total for the year, including specimens submitted from hospitals amount to 32, and that the figure for the first three months of 1955 shows a very substantial increase. It is, I think, well known now that this condition of the mother places the unborn infant at risk arising out of incompatability between the father's and the mother's blood. I am a little bit out of my depth here but I doubt if it is yet completely known what the ultimate end picture of these children born from incompatible parents may be. We do know, as I have pointed out before, that, among 8 children examined by a specialist in spastic disease of children, 3 were what we call Rhesus babies. That, if nothing else, is ample justification for the continuation and expansion of this work until the ultimate target of 100 per cent. samples submitted is reached.

With regard to syphilis, in 5 cases out of the 722, the diagnosis of an existing syphilitic infection was obtained.

The last thing I need say about this matter, is that we have endeavoured to help progress as far as we can by allowing our County Council outfits for the taking of blood samples in this connection to be made interchangeable with and available for blood samples taken in cases booked by doctors which are not therefore classified as midwives cases and are not our responsibility.

Gas and Air Analgesia

All our midwives, except one, are trained to administer gas and air. This means that this service is available to practically all women who desire to avail themselves of it at their confinements. During the year gas and air analgesia was employed in domiciliary midwifery or maternity by midwives to the extent of 925 cases. Of this number a doctor was present at 193 confinements and was not present at the remainder. The total figure shows a small increase from the previous year, in spite of the lower birth rate, and of course it has to be remembered that the figure of 925 out of

1,448 domiciliary confinements is not the end of the story, because in many cases classifiable as doctors' cases, the practitioners themselves administer the analgesic. The use of pethidine as an analgesic by midwives has extended considerably, the number of midwives authorised to use this sedative having been practically doubled during the year.

A new aspect in this matter of analgesia in midwifery has recently arisen out of the authorisation by the Central Midwives Board of the use of Trilene by midwives attending domiciliary confinements on their own after appropriate preliminary instruction. The value of this new analgesic over gas and air does not seem to me at the moment to be too clear. The substitution of the use of Trilene for gas and air on a wholesale basis in the county would involve the scrapping of the apparatus for the administration of gas and air which each midwife holds. The provision of gas and air apparatus to each midwife has involved the expenditure of some £2,000, and to replace these by the Trilene apparatus would involve a larger expenditure. All this would not matter if the advantages of Trilene were fully apparent. As I have said above, the evidence at the moment seems a little conflicting, and not as clear as it might be, and therefore the Health Committee, after considering all the available evidence, have decided to defer further consideration of the matter for the present.

MATERNAL MORTALITY

Four maternal deaths occurred during the year giving a maternal mortality rate of 1.13. The figures for maternal deaths in the last five years have been as under:

1950 — 5	deaths	equal to a rate of	1.28	per 1.000 births
1951 — 1	,,	,,	0.26	,,
1952 — 3	,,	,,	0.79	,,
1953 — 5	,,	,,	1.34	,,
1954 — 4	,,	,,	1.13	,,

Resuscitation by Oxygen

We have provided oxygen resuscitation outfits as recommended by the Association of Supervisors of Midwives to 20 of our midwives (including our whole-time district midwives) who undertake substantial numbers of domiciliary confinements annually, in the hope that

a few lives of infants who otherwise would not have survived, may be saved.

In this connection I think some extracts from a report by one of our midwives to the County Supervisor of Midwives may be of interest—

"I had occasion to use the oxygen resuscitator yesterday, with excellent results. I had a primipara of 31 who had a labour of only 6 hours with rapid, almost continuous contractions, the second stage lasted only twenty minutes, and when the baby was delivered it was quite a good colour and cried a little. When I was separating the cord it became very blue and limp and gradually the heart beat slowed down and stopped. I wrapped the baby in a warm towel but there was still no signs of life so I gave her oxygen with the face mask. After 2 or 3 minutes she became pink, the heart beat returned and gradually became stronger, and in five minutes I turned off the oxygen and she has been quite normal ever since.

"I had a very similar case about two months ago, in which in the absence of a resuscitator I gave mouth to mouth respiration. The child eventually responded but remained blue for 2 days. It was very interesting to compare the two cases and it gives one a much happier feeling to know that oxygen is available."

SECTION 24

Health Visiting

Our staff of whole-time health visitors at the end of the year amounted to 19 including 2 vacancies. In the rural areas of course, much of the health is undertaken by the district nurses of whom 45 are concerned, and of these 7 hold the health visitors certificate, the balance being continued under temporary year to year approval by the Ministry.

The work undertaken by our health visitors and district nurses during the year was as undernoted:

Visits to children under 1 year	31,135
Visits to children aged 1-5 years	35,223
	66,358

These figures represent a substantial reduction of some thousands from the previous year. This is prob-

ably attributable to the fact that the total number of live births in the county has fallen steadily and quite substantially during the past few years. Another factor may be that during the year we were short of 2 full-time health visitors for some months.

The work of the health visitors, and this I think is eminently desirable, is expanding in other directions. An increasing amount of time is being devoted to the visiting of aged persons in their own homes, and a substantial amount of time is devoted to problem families of whom some 144 were kept under observation in close co-operation with the Children's Officer during the year. The distribution of the families was as under:-

Rural districts.		Urban districts.	
Alston	3	Cockermouth ...	7
Border	26	Maryport ...	31
Cockermouth ...	3	Penrith ...	9
Ennerdale ...	24	Whitehaven Borough ...	10
Keswick ...	2	Workington Borough ...	16
Millom ...	3		
Wigton ...	10		
	71		73

SECTION 25

Home Nursing

The statistics relative to home nursing in respect of 1954 set out in accordance with instructions received from the Ministry are as follows:-

	No. of cases nursed.	
Medical	5.218	
Surgical	2,772	
Tuberculosis	317	
Infectious diseases	61	
Maternal complications	87	
Others	27	
	8,482	
Number of nursing visits paid ...	132,480	
Number of casual visits paid ...	5,005	
		137,485

The only comment I would like to make on the above figures is that included in them is the fact that almost 10,000 more *nursing* visits were paid to persons over 65 years of age compared with the previous year, and that 1,417 fewer *nursing* visits were paid to children under 5 years of age.

SECTION 26

Immunisation and Vaccination

(a) *Immunisation.*

The number of children immunised during the year under school age was 2,524. The number of school children receiving either primary or reinforcing injections was 4,238. In addition 118 pre-school children received reinforcing injections, so that we arrive at a total of 6,880 immunisations, primary or reinforcing, during the year. This figure of 6,880 immunisations includes 1,636 reports received from general practitioners in respect of children immunised privately, the majority of these being children under school age.

As mentioned in previous reports the number of immunisations carried out is probably substantially larger than the above figures show. It is quite certain that we have not any accurate knowledge of the immunisations carried out privately. We only learn of these when the practitioner carrying out the private immunisation sends in a report and claims the appropriate fee for the report, and it seems to be clear that many immunisations are carried out for which no fee is claimed. Immunisations carried out by practitioners refer in the main to children under school age. The majority of reinforcing or " booster " doses are given to children in school by members of our own medical staff.

The following table shows the trend in respect of immunisation including both the primary and reinforcing injections for the past 10 years: -

1954	...	...	6,880
1953	...	...	6,658
1952	...	...	8,915
1951	...	...	6,489
1950	...	...	7,161
1949	...	...	10,409
1948	...	...	7,235
1947	...	...	5,491
1946	...	...	7,318
1945	...	...	3,747

As mentioned last year the Ministry drew attention in a circular issued in November 1953 to the effect that a child who has not had a reinforcing injection during

the past 5 years cannot be regarded as completely protected against diphtheria. Last year we estimated that some 8,143 children of school age whom we have previously regarded as completely protected had to drop out of this category in view of the information contained in the circular referred to. I am sorry to have to report that this figure of 8,143 incompletely protected children during 1954 rose to 11,033. You will recall that the medical staff in West Cumberland was undermanned during much of the year, and also that there was a readjustment of duties of medical officers in East Cumberland. This year, of course, although our staff is complete, the new Mantoux testing and B.C.G. vaccination schemes in respect of 13 year old school children are making a new claim on the time of the medical officers. Nevertheless, I have reason to believe that by the end of 1955 our figures for children completely protected against diphtheria will show a substantial rise. That this service is more than justified is shown in a recent circular (5/55) issued by the Ministry from which the following comparisons at the two extremes of a 10 year period can be drawn:-

	1945	1954
Notifications of diphtheria ...	18,596	182
Deaths	722	9

It is pointed out that the figures for 1954 are at the time of writing provisional.

At the end of 1954 our percentage figures of children regarded as fully immunised were as follows:

Under 5 years	51%
5 up to 15 years	68%

We remain most grateful for the co-operation of the head teachers of the county schools in this matter, and in the rural areas the head teachers have allowed us to bring into school for immunisation children under school age which has proved of the greatest value. As a final point of interest there were no notifications of diphtheria in the county during 1954.

(b) *Vaccination.*

Vaccination is carried out by general practitioners in the county who have agreed to undertake this service and is not undertaken by the medical staff of the authority. During 1954 we received 1,115 record cards from practitioners in respect of successful primary vaccin-

ations and 198 cards in respect of re-vaccinations. Of the 1,115 primary vaccinations 948 referred to infants under 12 months. These figures, relative to the Registrar General's estimated population figures, give a percentage figure for successful primary infant vaccinations of 26%. All these figures are slightly lower than for the previous year.

SECTION 27

Ambulance and Sitting Case Car Service

No material change has taken place in this service during the year. The statistical table which follows compares the essential items — number of journeys, patients carried, total mileage, as affecting the three sections of the transport service (ambulances, sitting case cars, and hospital car service) — with the figures to 31st March, 1954. The table shows that during the year ended 31st March, 1955, there was an increase in the total number of journeys run of 496, a decrease of patients carried of 1,689, and an increase in total mileage of 4,162. The ambulance service proper showed a decrease of 357 journeys, of 792 patients carried, and an increase in mileage of 4,140, compared with the previous year. The sitting case car service and hospital car service combined, show an increase of 853 journeys, a decrease of 897 patients carried, and a mileage increase of 22.

Some of these figures may be a little difficult to understand, but one important factor affecting the statistics has been the substantial increase in the number of patients carried from various parts of the county to the thoracic surgical units at Seaham Hall and Poole Sanitorium. Reference is made elsewhere in this report to the welcome decrease in the waiting list for major surgical treatment for pulmonary tuberculosis, and of course this is a typical example of the axiom that you cannot have it both ways. In other words, if a substantial increase in the number of ambulance journeys for patients, mostly affecting single patients, and that of course over long distances, has been found necessary during the year, that is part of the price which has to be paid for the rehabilitation of many of our more serious cases of pulmonary tuberculosis, and I am certain that no-one will question the necessity for this.

There have too been an increasing number of long distance journeys often with individual patients to the Royal Victoria Infirmary and the General Hospital at Newcastle, and also to the Ministry's limb fitting centre at Newcastle and to hospitals in Edinburgh.

No new ambulances were purchased during the calendar year, but authority has been given to purchase two new vehicles during the current financial year.

The transport bureaux at the Cumberland Infirmary and Whitehaven Hospital continue to make a most valuable contribution to the running of an efficient transport service, and I am completely satisfied do much to keep the costs as low as they are.

	AMBULANCES.			SITTING CASE CARS.			HOSPITAL CAR SERVICE			SUMMARY OF ALL SERVICES.		
	Total No. of Journeys.	Total No. of Pats. Carried.	Total Mileage.	Total No. of Journeys.	Total No. of Pats. Carried.	Total Mileage.	Total No. of Journeys.	Total No. of Pats. Carried.	Total Mileage.	Total No. of Journeys.	Total No. of Pats. Carried.	Total Mileage.
Totals for year ended 31st March, 1954 ...	8,515	24,897	250,504	15,031	47,401	391,080	1,680	4,581	65,235	25,226	76,879	706,819
Totals for year ended 31st March, 1955 ...	8,158	24,105	254,644	15,833	46,741	392,250	1,731	4,344	64,087	25,722	75,190	710,981
Increase for year ended 31st March, 1955, compared with 1953/54	——	——	4,140	802	——	1,170	51	——	——	496	——	4,162
Decrease for year ended 31st March, 1955, compared with 1953/54	357	792	——	——	660	——	——	237	1,148	——	1,689	——

(Excluding journeys undertaken by other local Health Authorities).

FINANCIAL POSITION

I am indebted to the County Treasurer for the statement of costs which follows:—

Note by County Treasurer.

a. This note is submitted for information based on the costing statement attached.

In recent months Cumberland has been notified by the Durham County Council of ambulance charges totalling approximately £3,500 for transport by Durham of Cumberland patients for the four years ended 31st December, 1954. Inclusion of this amount in the attached statement would have resulted in misleading and fallacious comparisons, and accordingly, the figures which follow relate to vehicles owned by Cumberland or operated on their behalf.

b. **Mileage and number of patients carried viz.:—**

	1954/5	1953/4	
Ambulances (including dual purpose vehicles)			
Mileage	254,644	250,504	i.e. an increase of 4,140 miles.
No. of patients carried	24,105	24,897	i.e. a decrease of 792 patients.
Sitting Case Cars			
Mileage	456,337	456,315	i.e. an increase of 22 miles.
No. of patients carried	51,085	51,982	i.e. a decrease of 897 patients.
Total—			
Mileage	710,981	706,819	i.e. an increase of 4,162 miles.
No. of patients carried	75,190	76,879	i.e. a decrease of 1,689 patients.

c. **Cost**—including administration, depreciation and interest on vehicles—subject to recoveries from other county and county borough councils and subject to Ministry grant under the National Health Service Acts:—

	1954/5 Costs				1953/4 Costs			
	Amount	Per patient carried.	Per mile.		Per mile.	Per patient carried.	Amount	
	£	s. d.	s. d.		s. d.	s. d.	£	
Ambulances (including dual purpose vehicles) ...	22,435	18 7	1 9	...	1 8	17 1	21,246	
Sitting case cars	24,410	9 7	1 1	...	1 1	9 5	24,371	
TOTAL	£46,845	12 6	1 4	...	1 4	11 10	£45,617	

Points from the table are:—

1 **Expenditure**—in total, the amount increased by £1,228, i.e. from £45,617 (1953/4) to £46,845 (1954/5). The increase is almost wholly in respect of ambulances.

	Ambulances (including dual purpose vehicles).	Sitting Case Cars.	Whole Service.
2 **Cost per mile**—			
1954/5 compared with 1953/4	Small increase of 1d. to 1/9d.	Same at 1/1d.	Same at 1/4d.
3 **Cost per patient carried**			
1954/5 compared with 1953/4	Increase of 1/6d. to 18/7d.	Increase of 2d. to 9/7d.	Increase of 8d. to 12/6d.

COST OF AMBULANCE SERVICE (EXCLUDING CHARGES BY OTHER LOCAL AUTHORITIES) FOR THE YEAR TO 31st MARCH, 1955.

	1954/5				1953/4			
			Cost		Cost			
	Patients carried. 1.	Mileage. 2.	Amount 3.	Per mile. 4.	Per mile. 5.	Amount. 6.	Mileage. 7.	Patients carried. 8.
			£	s. d.	s. d.	£		
Ambulances and dual purpose vehicles:—								
1. Vehicles owned by County Council and run on their behalf by agents:—								
a. Running expenses (excluding depreciation) ...			(12,525 ...	1 4.3	1 3.6 ...	11,743)		
b. Depreciation and interest on vehicles based on life of 10 years	14,772 ...	183,861	(			)	180,954 ...	15,407
			(3.060 ...	4.0	4.0 ...	3,003)		
	14,772 ...	183,861 ...	15,585 ...	1 8.3	1 7.6 ...	14,746 ...	180,954 ...	15,407
2. Vehicles owned and run by a garage proprietor ...	9,333 ...	70,783 ...	4,875 ...	1 4.5	1 4.3 ...	4,711 ...	69,550 ...	9,490
3. Direct administrative expenses:—								
a. Call-out bureaux—proportion	—— ...	**254,644** ...	264 ...	.2	.2 ...	219 ...	**250,504**	——
b. Telephone filter service, equipment, medical supplies, printing, stationery, etc.	—— ...	**254,644** ...	464 ...	.4	.4 ...	438 ...	**250,504** ...	——
4. Indirect administration expenses—share of cost of central departments	—— ...	**254,644** ...	1,247 ...	1.2	1.1 ...	1,132 ...	**250,504**	——
5 TOTAL—AMBULANCES	24,105 ...	254,644 ...	£22,435 ...	1 9.1	1 8.4 ...	£21,246 ...	250,504 ...	24,897
Cost per patient carried: 1954/5 18/7; 17/1 1953/4								
Sitting case cars:—								
6. Vehicles of hire car proprietors	46,741 ...	392,250 ...	20,009 ...	1 0.2	1 0.2 ...	19,936 ...	391,080 ...	47,401
7. Vehicles of hospital car service volunteers (including grant to Red Cross for administration) ...	4,344 ...	64,087 ...	2,025 ...	7.6	7.6 ...	2,076 ...	65,235 ...	4,581
8. Direct administration expenses:—								
a. Call-out bureaux—proportion	—— ...	**456,337** ...	909 ...	.5	5 ...	184 ...	**456,315** ...	——
b. Printing, stationery, etc.	—— ...	**456,337** ...	111 ...	.1	.1 ...	876 ...	**456,315** ...	——
9. Indirect administration expenses—share of cost of central departments	—— ...	**456,337** ...	1,356 ...	.7	.7 ...	1,299 ...	**456,315** ...	——
10. TOTAL—SITTING CASE CARS	51,085 ...	456,337 ...	£24,410 ...	1 0.8	1 0.8 ...	£24,371 ...	456,315 ...	51,982
Cost per patient carried: 1954/5 9/7; 9/5 1953/4.								
11. TOTAL FOR AMBULANCES AND SITTING CASE CARS—the cost being subject to recoveries from other County and County Borough Councils and subject to Ministry grant under the National Health Service Acts	75,190 ...	710,981 ...	£46,845 ...	1 3.8	1 3.5 ...	£45,617 ...	706,819 ...	76,879
Cost per patient carried: 1954/5 12/6; 11/10 1953/4.								

SECTION 28

Prevention of Illness, Care and After-Care

This section is, on the one hand, the most ambiguous, and on the other the most important, or at least certainly not the least important section of the National Health Service Act. It is the most ambiguous because it overlaps so much with other sections. In fact it interlocks with all the sections in Part III of the Act.

In the matter of tuberculosis, which provides one of the most fruitful fields for preventative medicine, we co-operate closely with the consultant chest physicians in East and West Cumberland, and, as noted last year, two of our health visitors in West Cumberland have been seconded half time to chest centre work proper, and the other half of their time is devoted to domiciliary visiting almost entirely in connection with the chest centre work, and in co-operation with the chest physicians.

During the year the foundations were laid for the start of B.C.G. vaccination of school children in the 13 year old age group. This will have been completed so far as 1955 is concerned by the time this report is in your hands. Elsewhere in this report the Deputy County Medical Officer (Dr. Minto) has dealt with this matter in detail. All of our medical staff have undergone special instruction in this matter and all are taking part in this important service. At the chest centres a considerable amount of B.C.G. vaccination of contacts of tuberculous cases is undertaken. The total number of contacts vaccinated up to the end of 1954 from the commencement of this work was 1,273 of whom 686 were vaccinated during 1954.

We still issue at the request of the chest physicians, on loan, open-air shelters to tuberculous households up to the number of 25 as may be required. With increased hospital provision the demand for these shelters is now much less than formerly.

The number of visits paid by our nurses to tuberculous households in 1954 apart from nursing visits. amounted to 6,219, involving 1,558 households. We continue when required to provide beds and bedding to enable an infective patient to sleep alone. During the

year we provided domestic help to 16 households with tuberculous patients. In the matter of housing most of the sanitary authorities in the county give high priority to the rehousing of tuberculous families, and in a number of other cases in which bad housing has been proving detrimental to the inmates' health, we have collaborated with the housing authorities in bringing the position to their notice. Our transport service, both of ambulances and sitting-case cars, plays an important part in the care and after-care of patients in bringing them to appropriate centres for investigation and treatment of one kind or another. One of the most important aspects of this matter is the attendance at physiotherapy clinics attached to, or operating in association with, the hospitals, at which clinic treatment of various kinds is employed to rehabilitate patients after illness, in-patient treatment, accidents and so on. Without the transport service much of this rehabilitation work would be impossible for patients living in the rural areas.

A reference is made elsewhere in this report to the blood examination of expectant mothers in connection with domiciliary confinements. This aspect I am glad to say is expanding.

Our loan equipment scheme which involves the issue of both major and minor equipment continues to be increasingly utilised by our district nurses. This equipment consists of such items as invalid chairs, air and water beds, premature baby cots, etc., and in respect of medical equipment covers a considerable variety of items. This equipment is now stored at five depots in the county, at Penrith, Carlisle, Maryport, Whitehaven and Millom. In the building of our new clinics we are, in each case, providing a room for the storage of this equipment so that it can be made readily accessible.

In the matter of contact tracing in connection with venereal disease we continue to co-operate with the consultant venereologist. The incidence of V.D. is, of course, definitely falling in this county and the number of visits paid by our nurses in this connection has therefore shown a substantial fall.

Our health visitors, including district nurses acting as health visitors, continue to pay many visits of an advisory nature which is, of course, one of their most important functions as defined under paragraph 30 of

Circular 118 issued by the Ministry in July 1947. The number of such visits paid under the above general heading during 1954 was 831. This figure is additional to, and is not included in the statistics given under the heading of " The Nursing Services " early in this report.

The number of patients sent for convalescent treatment at the request of general practitioners during the year amounted to 22. This number is small but is actually double the number for 1953. We would be very glad to send more cases for convalescent treatment if these were brought to our notice. This provision deals with persons in need of convalescence who are not eligible for convalescent treatment through the hospital service, that is to say, persons who have been ill at home. The patient sent for convalescent treatment by a local health authority is at some disadvantage compared with the patient sent by the hospital authority for convalescent treatment because the patients we send are required by regulation to contribute to the cost of convalescent treatment according to their means. This involves of course, obtaining a statement of income. I do not like this and I see no sense in the distinction, but it exists, and we are required to operate it.

One small matter. We took what I think was a progressive step during the year. A Sunshine Home was opened in the South of England for the reception of mothers with young blind babies. The object of the home is to assist the mother to overcome the handicaps of the child's disability. At the moment of writing we have not yet received the approval of the Ministry to this provision but I hope that that will come. I expect to visit the home in question during the early summer to see for myself what happens.

We have approached the Ministry for permission to vary our " proposals " in respect of immunisation and vaccination by adopting a model proposal suggested by the Ministry which would enable a health authority to provide immunisation or vaccination as the case might be as a preventative measure in respect of any illness in which such a step might be shown by experience to be of practical value. One ailment for which in the future such a measure to produce immunity might well arise is infantile paralysis. This modified or model proposal gives an authority adopting it, with the approval of the Ministry. wide powers to act.

SECTION 29

Home Help Service

This service which has now been in operation for almost seven years continues to work smoothly and efficiently. The arrangement whereby the Superintendent Nursing Officer is also the organiser of the home help service, which I think only exists in one or two counties, continues to prove very successful. The work by this arrangement can be shared with the deputy and assistant Superintendent Nursing Officers, and the arrangement also brings the district nurses closely into the picture.

During the year the Superintendent Nursing Officer and her assistants paid 1,977 visits in connection with the service, of which 1,279 were to the actual households requiring help through the service, or to which home helps had been directed, and 698 were to home helps either before enrolment or in the course of their duties.

The home helps frequently call at our Carlisle and Whitehaven offices for instructions, and the Whitehaven office keeps in close touch with the head office in connection with any problem cases.

The statistics for the year which follow, show no great variation from the previous year. The number of applications received for home helps has fallen fairly substantially. The number of persons willing to be registered as mobile and resident home helps has now been reduced to one, and even this one is only prepared to undertake this class of work at intervals. An increasing number of the enrolled home helps prefer part-time rather than whole-time service.

With regard to the distribution of the home helps, this remains much as before with the exception that in Millom we have been able to recruit one or two additional home helps, but in Keswick the figure still remains almost negligible in spite of recent advertisements. I suppose the answer is that women who might in another part of the county be willing to enrol as home helps are in Keswick during a large part of the year occupied with letting rooms to visitors, and in helping in the hotels and boarding houses.

The bias of the service continues very much towards the old age and infirm, and allied types of cases. Actually the number of cases in this group helped during the year has risen quite substantially. These are almost invariably long stay cases, and that is why in the annual statistical returns published by the Society of County Treasurers, this county shows up below the average in respect of the cost of the service per thousand of the population, but considerably above the average, in fact the highest of the English counties, on the basis of cost per case. I have pointed out before, and I think it worth repeating that the health authority which concentrates as we do very largely on the aged infirm and senile type of case which is inevitably long stay must show a substantially higher cost per case than another area in which attention may be concentrated on confinement and short stay cases where the turnover is infinitely quicker, and therefore the cost per case is correspondingly reduced.

The new scale of assessment charges adopted by the council in 1953 continues to operate smoothly, and apparently creates no embarrassment even to the poorest households. It is fair to say that there have been a few cases in which households whose family income is such that the full standard charge was payable have withdrawn their application on the grounds that the cost would create financial embarrassment.

NIGHT SITTERS.

This matter which is closely allied to, and might almost be said to be an extension of the home help service, is dealt with elsewhere in this report.

The statistics for the year are as follows:-

1st January 1954 to 31st December 1954.

Home Helps.

No. of persons who have been accepted and enrolled on the register:-

Whole-time	50
Part-time	150
Mobile (Resident)	1
	201
Less persons resigned from service ...	21
No. on register at 31st December, 1954 ...	180

Districts in which the home helps reside:-

Alston	7	
Aspatria	16	
Border Rural	37	
Cockermouth	4	
Ennerdale Rural	19	
Keswick and Threlkeld	1	
Maryport, Dearham and Gt. Broughton	19	
Millom and District	8	
Penrith and Penrith Rural	18	
Silloth	11	
Whitehaven, Distington and St. Bees	11	
Workington	11	
Wigton and Mealsgate	18	
		180

Householders.

No. of applications received for home helps	455	
No. cancelled or not supplied	175	
No. of new cases helped	265	
No. of cases on books 1st January, 1954	236	
Cases pending	36	
Analysis of cases helped:-		
Confinements	79	
Tubercular cases	16	
Old age and infirmity	190	
Mental health	3	
Cardiac	45	
Blind	13	
Cancer	3	
Illness of long duration (cerebral haemorrhage, rheumatoid arthritis, etc.)	85	
Illness of short duration (post-operative, influenza, etc.	67	
		501

SECTION 51

Mental Health Service

The report on the Mental Health Service follows the lines indicated by the Ministry in Circular 28/54.

1. ADMINISTRATION

There has been no change in the administration of the Mental Health Service which continues under the immediate control of the Mental Health Sub-Committee of the Health Committee, and to that Sub-Committee are co-opted members (not members of the County Council) who have valuable contributions to offer in the field of community service, and with special emphasis on the mental health aspect.

In such a personal service as the domiciliary mental health service there must be established and maintained a very high degree of co-ordination and co-operation between those responsible for the hospital side of mental deficiency and illness, and the local authority's staff. Certain specialist officers of the Regional Hospital Board continue to be seconded for part-time duties on behalf of the local health and education authorities. Our medical and non-medical staff work in the various fields of mental health in close co-operation with the hospital authority and its officers, there is free access to and exchange of information between the local domiciliary service and the hospital authorities in relation to mental health. Such co-operation can only be of mutual help, and apart from the benefits accruing to patients by this easy "pooling" of information and resources, a great deal of unnecessary over-lapping of individual responsibility is obviated. This liaison is not confined narrowly to those directly concerned with mental health, but extends to other departments of the County Council, to medical and surgical consultants, to general practitioners, and to other bodies and agencies such as the police, probation officers, Ministry of Labour, the National Assistance Board, and many other official and voluntary bodies.

A number of staffing changes occurred during the year. Dr. Minto, who succeeded Dr. Gilloran as Deputy County Medical Officer and Deputy Principal School Medical Officer, was appointed a Certifying Officer for the purposes of the Mental Deficiency Acts, and he is also approved for the purposes of the Handicapped Pupils Regulations. Dr. Patterson, who was appointed in December to succeed Dr. Mason as Assistant County Medical Officer, is also approved for the purposes of these regulations. In January 1955, Miss Simpson, our only whole-time psychiatric social worker, left to take up another appointment elsewhere, and we were fortunate to obtain the services, at least on a part-time basis and for a temporary period, of Mrs. Campbell. Mrs. Lax resigned her post as supervisor of the Whitehaven Occupation Centre in September for domestic reasons; Miss Magee, the supervisor at Wigton was transferred to the larger Whitehaven Centre and Miss Story was promoted from assistant supervisor to supervisor at the Wigton Occupation Centre. Mrs. Eland

was appointed to fill the vacancy created by Miss Story's promotion. Miss Cox resigned her position as assistant supervisor at Whitehaven Occupation Centre in January and Mrs. Sowerby was appointed to the vacancy.

The Ministry ask that the staff employed in the mental health service be set out in detail as follows:-

Certifying Officers (Mental Deficiency Acts, 1913-1938): Dr. Fraser, Dr. Minto.

Approved Medical Officers	Dr. Fraser, Dr. Minto, Dr. Gallagher, Dr. Hunter, Dr. Jones, Dr. Patterson, Dr. Perrott, Dr. Thomson, *Dr. Ferguson, *Dr. Braithwaite, *Dr. Stuart.
Psychiatrists ...	Dr. Braithwaite, Dr. Ferguson, Dr. Stuart (all seconded from the Regional Hospital Board).
Mental Health Officer	Mr. Froggatt.
Mental Health Workers	Miss Hall, Miss O'Regan.
Psychiatric Social Workers	(a) West Cumberland—Mrs. Campbell (part-time). (b) East Cumberland — Miss Lamb, seconded from the Special Area Committee in connection with the East Cumberland Child Guidance Centre.
Occupation Centre Supervisors ...	Miss Magee, Miss Story.
Occupation Centre Assistant Supervisors ...	Mrs. Eland, Miss Lister, Mrs. Sowerby.
Handicrafts Teacher	Miss Cooper.
Duly Authorised Officers	Mr. T. J. Archer, Mr. J. J. Brown, Mr. A. Corlett, Mr. W. H. Coulthard, Mr. J. Gibson, Miss J. Gibson, Mr. A. Glaister, Mr. J. H. Hocking, Mr. J. Housby, Mr. D. W. Jack, Mr. T. Johnston, Mr. J. D. Messenger, Mr. H. Sewell, Mr. W. J. Wilson.

* Approved for cases in connection with the child guidance centres.

2. WORK UNDERTAKEN IN THE COMMUNITY

(a) Under Secion 28, National Health Service Act, 1946.

The prevention of mental ill-health and the care of the mentally ill and the mentally defective are subjects

of growing consideration, and medical officers of health are specially requested to review work done in this field in their annual reports for the year 1954. Section 28 of the National Health Service Act conferred on local health authorities the power to make arrangements for the prevention of mental illness, and for the care and after-care of the mentally sick and defective. We must I think consider these questions in two sections—firstly in connection with deficiency of mind and secondly in relation to mental illness.

By legal definition, deficiency of mind is a condition of arrested or incomplete development of mind "existing before the age of 18 years whether arising from inherent causes or induced by disease or injury." So comparatively little is known about the cause of mental deficiency that local health authorities can do nothing towards preventing mental deficiency. We are not dealing with a physical condition of known causation, as for example in the case of diphtheria where the causative organism can be isolated and where positive preventative action can be taken in the form of immunisation to lower the incidence of the disease. It is felt, however, because of our comparative helplessness in the prevention of mental deficiency that much greater facilities (and much more money) should be made available for study and research into the problem of why apparently normal parents may produce a mentally defective child. At the same time, we must acknowledge, in the light of our present knowledge into genetics, that where one or both parents are mentally sub-normal, children of the union rarely prove to be of normal intellectual development. In these cases the incidence of mental deficiency in the community could probably be reduced, but only by the introduction of highly contentious legislation.

If we view certifiable deficiency more from the aspect of social inefficiency and inadequacy, rather than from the purely attainment view-point as measured by intelligence and performance tests, some useful preventative work might be undertaken if powers were available to enable local authorities to exercise some degree of supervision and help to "backward" children, who cannot be certified as defective on leaving school, and who in consequence are not within our jurisdiction. The formative years between leaving school and reach-

ing adult life are particularly difficult to the educationally sub-normal. Timely guidance and control may well prevent deterioration to certifiable levels of social inadequacy among a group which undoubtedly at present constitutes a difficult social problem, providing as it does a relatively large proportion of delinquents or people who cannot adequately manage their affairs without assistance, and ultimately engenders what we now know as " problem " families.

The care and after care of the mental defectives in the community is now a well established service. The specialist mental health workers play the biggest part in this work, but in carrying out their duties, they inevitably enlist the aid of a considerable number of other officers of local authorities, of public bodies and voluntary associations. This very necessary community service must of course work in close liaison with the Regional Hospital Boards, whose responsibility it is to provide hospital accommodation for defectives as and when necessary.

Turning now to mental ill-health, there is slowly developing a greater awareness of the problem. The stigma which was attached to illness of the mind is slowly being broken down. The hospitals used for the treatment of mental disorders are gradually coming to be regarded by the general public as *hospitals*, and the ease with which patients can be admitted to mental hospitals and, what is probably more important to anxious relatives, the ease with which they can be discharged from such hospitals, is becoming more widely known and appreciated. Many of the mental disorders are organic in origin and therefore much active preventive work can be undertaken. In Cumberland, psychiatric out-patient clinics are held at the three principal hospitals in the county by the Medical Superintendent of Garlands Hospital and his staff, and the services of psychiatric consultants are easily available to the general practitioners for domiciliary cases. The value of these clinics and consultant services in the prevention of mental illness cannot be over-estimated, in that they provide facilities for early diagnosis and treatment (often without admission to hospital) so that in many cases the progression of minor mental illness to the stage of serious mental disorder can be halted. The key of course to this preventive aspect lies with the general practitioner. He remains the first contact

with the patient, whom he knows intimately, and a great deal depends on his referral of early mental ailment for expert opinion and advice. Our child guidance centres, although primarily the responsibility of the education authority, obviously make some useful contribution to the prevention of mental disorders in later life. The only other useful contribution which we can make in this field lies along the lines of disseminating information.

Probably the weakest link in the mental health service is the general inadequacy of arrangements for the after care of the mentally sick. The services available in this direction vary greatly in degree over very wide ranges in different areas, and this is due in my opinion, to the division of responsibility for this work between the hospitals (through the Regional Hospital Boards) and the local health authorities. The local health authority has no *duty* to arrange for the after care of the mentally sick, but it *may*, if requested by the hospital authority, assist the hospitals in the after-care aspects of their work. This position means that whilst in one area the local health authority makes no contribution to the after-care of the mentally ill, a neighbouring council's mental health service may be giving appreciable help if asked in the after-care of its patients to a mental hospital. Some mental hospitals quite frankly do not wish the local health service to take any part in the after-care of its former patients. In Cumberland, as in many other districts, the local health authority is quite unable to undertake any after-care of the mentally sick for the reason that adequately trained staff are simply not available.

A five year survey of the progress made nationally under Sections 28 and 51 of the National Health Service Act, reveals that only " between 20 and 30 authorities have obtained the services of a psychiatric social worker." Recruitment to the profession falls far short of the number still required. The result is that the burden of the after-care of the mentally sick, which has a domiciliary as well as hospital angle, is left entirely to the Garlands Hospital through its out-patient clinics, having only the service of a single (and I am sure, overworked) psychiatric social worker, to cover the whole of Cumberland, the City of Carlisle and part of Westmorland.

(b) Under the Lunacy and Mental Treatment Acts, 1890-1930.

The function of the local health authority under these Acts is to appoint "duly authorised officers" to take initial proceedings in providing care and treatment for persons suffering from mental illness. In Cumberland, these officers are primarily engaged for registration and other duties, and their services under the Lunacy and Mental Treatment Acts occupy only a very small proportion of their time, which is largely confined to the completion of arrangements for the admission to hospital of those classes of patient (certified and temporary) in whose cases legal formalities are involved.

During the year under review, a total of 375 Cumberland patients were admitted to mental hospitals under the provisions of the Lunacy and Mental Treatment Acts and of these all but 17 were admitted to Garlands Hospital. An analysis of the total admissions between the various classes of patient (certified 47, temporary 9, voluntary 319) again reveals that more than 80 per cent of cases entering mental hospitals for treatment did so voluntarily and without legal implications. This is another indication of the changing and more enlightened attitude to mental illness. On the other hand, the average age of certified cases admitted during the year was 53 years, and it is rather disturbing to note that included in this group are four patients over 80 years of age, and ten over 70 years. Discharges during the year totalled 292 (certified 26, temporary 1, voluntary 265); deaths numbered 58.

(c) Under the Mental Deficiency Acts, 1913-38

(i) ASCERTAINMENT

During the year 37 persons were officially "ascertained" as being mentally defective within the meaning of the Acts, and all but two of these were "subject to be dealt with" as defectives. Of the total of 35 defectives in respect of whom the Local Health Authority had statutory duties for the first time, 14 were children found to be ineducable within the scholastic system, who were reported by the Education Authority under Section 57(3) of the Education Act, 1944. In addition 8 boys and girls were reported by the Education Authority under Section 57(5) of the Education Act whilst still in attendance at ordinary schools who were

considered to require supervision after leaving school, the balance of thirteen new cases being from other sources (general practitioners, National Assistance Board, etc.).

All these cases were included in the total of 280 referred to the Mental Health Section for investigation during the year. In addition to those found mentally defective, 72 cases were referred to the child guidance centres because of maladjustment, behaviour disorders, etc., 52 children were considered to be educationally sub-normal and requiring special educational treatment in special schools for this type of child, and 18 were referred to the Education Authority with the recommendation that they be given some specific type of special tuition whilst remaining in the ordinary schools.

(ii) SUPERVISION

At the end of the year the total number of defectives for whom the County Council was responsible was 618, and of these 278 were under some form of domiciliary supervision, the remainder being in institutions. The cases remaining in their own homes may be broken down into three main groups—under statutory supervision 193, under guardianship 48, and under voluntary supervision 37. Comment was made in my last annual report on the difficulties of the mental health workers in attempting to secure adequate domiciliary care in many cases, because of the enforced retention within private homes of patients who could only adequately be cared for under hospital conditions. As will be seen later in this report, this position has been eased by the transfer to hospital care of some of our most troublesome cases. Nevertheless, the total number remaining under domiciliary care (278 as compared with 292 in 1953) shows only a very slight decrease by comparison with last year in spite of a relatively high number of hospital admissions, and this of course is due to continued activity as regards ascertainment.

I would like to make special comment on the benefits which have resulted from the scheme of short term care for defectives, which was introduced by Circular 5/52 of the Ministry of Health in January, 1952. This circular authorised the admission of patients to hospital care for temporary periods without legal formalities. The scheme was originally used for tiding

over temporary crises within a family which contained a mental defective, such as the sudden illness of the mother. Its scope in Cumberland has been considerably widened, and this is due to the excellent co-operation by the hospital authority, and in particular by Dr. Ferguson, the Medical Superintendent of Dovenby Hall Hospital. During 1954, 28 defectives were admitted for what is known as short term care, the corresponding figures for 1953 and 1952 being 21 and 10 respectively. The length of stay varied between one day and 129 days, the average being just over 53 days. If we look at the reasons for admission, some idea is given of the usefulness of the scheme generally. In 9 cases defectives were admitted to give the responsible relative a respite from caring for troublesome patients, in 7 cases because of the mother's illness or confinement, in 6 cases for observation of the physical or mental condition (or both), in 3 cases for some specific medical treatment, in 2 cases to enable parents to have a holiday and in 1 case to tide over a period pending presentation of a petition for an Order of admission.

Finally, and once more indicating the degree of co-operation between the Hospital Management Committee and the local health authority, a scheme has been approved and is in full operation for the dental treatment at Dovenby Hall Hospital of defectives normally living in the county area. Not infrequently was it found that patients under domiciliary care could not easily obtain necessary dental treatment because neither the dental practitioners nor the general hospitals have proper facilities for the dental treatment of defectives. These facilities existed at Dovenby Hall Hospital, and so an arrangement was made (which is shared by the City of Carlisle authority) for defectives to be dentally inspected and treated at Dovenby where (if necessary) they can be detained for a day or two to recover from their treatment.

(iii) GUARDIANSHIP

By the end of 1954, the number of cases under guardianship had fallen to 48, a net reduction of one by comparison with the previous year, which is the result of one death, the transfer of one patient to institutional care, and the appointment of a guardian to a child who had previously been under statutory supervision in her own home. Of this total of 48 cases, 4

were under 16 years of age and in these cases the local health authority makes a small weekly grant towards maintenance and a quarterly payment to assist in clothing the defectives.

I have commented in previous reports that the statutory scheme for placing defectives under Order to suitable guardians is falling into disuse because of changes in circumstances which have arisen since the principal act became law. If we look at Cumberland's figures since the appointed day (when the mental deficiency services devolved on the local health authorities of Cumberland, Westmorland and Carlisle City as distinct from the previous voluntary association) it is noted that the total of patients under guardianship orders has fallen gradually from 72 to the present figure of 48 mainly because the number of cases who have died, who have been discharged from Order and who have been transferred to institutional care, greatly outnumber the total of cases newly admitted to guardianship. In fact, during the six years to the end of 1954, only six cases were newly admitted to guardianship conditions, and it is significant that of these, four were children who were placed under the statutory guardianship of a parent, not for the purpose of improving the degree of care, training or control, but solely to legalise the payment of small sums by the local health authority to help with the maintenance of the child.

The guardianship provision is a very useful medium but only in a small percentage of the total cases, which includes docile, easily managed adults of medium grade who will never be capable of maintaining themselves or leading a life in the community independent of outside help, and a very limited number of children living in good home surroundings with parents who are capable of providing the additional care and training needed by a defective child. The number of cases originally under guardianship in Cumberland (and indeed the number remaining under guardianship at present) represents a much higher percentage of the total ascertained defective population in the county than is general throughout the country as a whole. At the end of 1953, which is the last date for which national figures are available, only 2.3 per cent of the defectives in England and Wales were subject to Guardianship Orders by comparison with 8.3 per cent. in Cumberland.

This is because the guardianship provision was applied, particularly in the early 1930's, in this area as a " second-best " to institutional admission which for some reason was at that time impracticable. The present inevitable position therefore is that of the 44 adult defectives under guardianship, 8 are over 60 years of age and 11 are between 50 and 60 years, the average age of adults under guardianship being 46. Very frequently the parents were originally appointed as guardians to defectives and in a large proportion of cases the guardian is 20 or more years older than the patient, so that the average age of guardians in the county is alarmingly high. Not infrequently it has become necessary at very short notice to attempt to secure institutional accommodation for a defective under a Guardianship Order whose aged guardian has become critically ill or has died.

To summarise this section, I would submit that, whilst of limited application, the guardianship provision is extremely valuable in certain cases in that it provides a greater degree of control than is afforded by statutory supervision, and yet enables the patient to enjoy a home life in the community. There is, however, increasing difficulty in finding suitable persons to undertake the quite onerous duties of guardian to a defective, and I can see little point in nominating a parent as guardian to a defective, because if the parental home affords suitable care, protection and control, these conditions will not be enhanced by a statutory order of guardianship. I think the ultimate solution, if the guardianship scheme is to continue, would be to encourage suitable persons to establish small guardianship homes where the persons in charge could be appointed guardian to a small number of defectives of the same sex, being paid by the local health authority allowances which would more than cover the bare subsistence of the patients. In other words, I think the guardianship scheme has to be made sufficiently attractive financially as to encourage the right type of individual to make it a means of livelihood.

(iv) OCCUPATION AND TRAINING

There are three main forms in which the local health authorities attempt to carry out their duties in providing " suitable training or occupation " for defectives. First, there are the training centres (known as

"occupation centres") which are run very much on the lines of primary schools where the defectives attending are in the main of school age, but where the training is naturally more on the social and practical than on the academic side. Secondly, in the more densely populated areas, occupation centre training is followed for older defectives in what is known as an industrial centre, which is organised somewhat on the lines of the the Remploy factories of the Ministry of Labour, and provides training, occupation and supervision for adult defectives who are unemployable in the usual sense. Lastly, individual training of defectives in their own homes is sometimes given in those areas where it is not practicable to organise communal training either because of geographical consideration or because of associated physical disability in the defectives which make it impossible for them to travel to group centres. At the end of 1954, of the 278 defectives supervised in their own homes by the local health authority, 111 were considered to be suitable for one of these types of training; 73 being thought suitable for occupation centre training, 21 for training in industrial centres and 17 for home teaching.

The provision of facilities for training in occupation centres has been improved very considerably in Cumberland since the appointed day. We now have two whole-time occupation centres in the county (one at Whitehaven and one at Wigton) and by arrangement with the Carlisle City Authority, we can admit a limited number of county children living within travelling distance of Carlisle to the occupation centre run by the City authority. By the end of the year 47 defectives were in regular training at occupation centres, 35 at Whitehaven, 10 at Wigton and 2 at the Kingstown Occupation Centre, Carlisle. There are no industrial centres in the county, and I cannot foresee that there will, at least for very many years ahead, be a sufficient demand for this form of provision even in the comparatively thickly populated areas of West Cumberland, to make such a centre an economic possibility.

As I have mentioned in previous reports, there is considerable difficulty in providing facilities for the training of defectives even in small groups over the whole of the county area in a rural county such as Cumberland. Whitehaven and Wigton were selected for

the siting of occupation centres because both the centres could act as foci for reasonable drainage areas from a travelling point of view, but there are in addition to areas served by these centres, small pockets of population within the county and a number of odd cases in small hamlets and villages scattered throughout the remaining areas covered by the county administration, all of whom have an equal claim on the health authority for adequate training provision. This situation of course is constantly under review, and the whole question was considered in detail towards the end of 1954 by a special sub-committee which was appointed to look into this problem throughout the county area. It was evident that there were a number of defectives suitable for occupation centre training who were without facilities for such training. These occurred in very small numbers at Millom, Keswick, Penrith and Longtown, but the bulk of the defectives living outside the drainage areas of the existing centres were scattered throughout the county in single cases. Similarly, when the question of home or group teaching was considered, there appeared to be a sufficient demand in Penrith for at least a group class, but generally the cases who were considered suitable for this form of training, occurred in single cases distributed throughout the county.

The Whitehaven Centre measures up to modern standards to a fair degree, and can be considered adequate for present needs, but if the rate of ascertainment of new cases continues at its present level, it will be necessary to enlarge the premises by adding at least one good sized room in the not too distant future, but as the structure is single storeyed and pre-fabricated, this should prove to be neither difficult nor unduly expensive. The Wigton Centre has always done a commendable job under difficult conditions, consisting as it does of one medium size (rented) room with no outside facilities. Plans for a new centre at Wigton have been drawn up and approved by the Council. A suitable site has been agreed upon, and as soon as the Minister's formal approval is received, the building of the proposed new centre will commence. It may be necessary when the new centre at Wigton is in full operation to arrange some re-distribution of collecting areas as between the Whitehaven and Wigton Centres with the dual object of relieving pressure on the White-

haven Centre and in the building up of a more workable unit at Wigton. If and when it is possible to secure the services of a suitable teacher, the Committee has authorised the establishment of a group class at Penrith on two or three half days a week, and I am also authorised to arrange for the establishment of similar classes in any other district in the county where the need for such classes arises.

Finally, I should comment on the fact that, again as the result of more hospital beds being available for defectives, the character of the occupation centres is gradually conforming more to the type which was envisaged when this form of training was instituted. For many years past, low grade, anti-social and physically handicapped defectives, who ought to have been under institutional care, and who were unable properly to benefit from occupation centre training, were admitted to the day centres solely to provide relief to relatives. The presence of these types of defectives obviously retarded the progress of the medium and higher grade defectives. During 1954, however, many of these patients have been admitted to hospital so that the general level of training in the centres has been lifted. I would also like to mention that on two or three occasions during the year, children who have not been certified as ineducable within the scholastic system have been admitted to the occupation centre by agreement with the Director of Education and with the full co-operation of their parents in an attempt either to stabilise their behaviour or to obtain a more accurate assessment of the child's potential. The experiment has been in the main successful. In one case the child's behaviour deteriorated still further and it became necessary to admit him to Dovenby as an urgent case. In two other cases social behaviour improved, at least to the extent that the children became testable by normal intelligence and performance test methods, and although both were ultimately found to be mentally defective and were excluded from school for this reason, at least their conduct both in the home and at the centre showed considerable improvement. One boy's behaviour in school was such that his presence in an infant class was very detrimental to the other children. After a comparatively short spell at the occupation centre however, his social behaviour improved to such an extent that he has been re-admitted to an ordinary school.

3. INSTITUTIONAL TREATMENT

Of the 618 defectives for whom the County Council was responsible at the end of 1954, 340 were either in institutions or on licence from institutions as follows :—

	1954	1953
In the area of the Newcastle Regional Hospital Board:-		
Dovenby Hall Hospital, Cockermouth ...	241	204
Durran Hill House, Carlisle	7	7
Aycliff Hospital, Heighington, Darlington	9	7
Morpeth and Northgate District Hospital	4	5
Lemmington Hall, Alnwick	2	2
General Hospital, West Hartlepool ...	2	2
Prudhoe and Monkton Hospital, Prudhoe	3	1
Bishop Auckland Institution, Durham ...	1	1
In other Regions:-		
Milnthorpe Hospital, Kendal	30	32
Royal Albert Hospital, Lancaster	20	20
Lisieux Hall, Chorley	3	3
St. Mary's Home, Alton, Hants	2	2
Hortham Colony, Almondsbury, Bristol ...	2	2
Coleshill Hall, Birmingham	1	1
Monyhull Hall, Birmingham	1	1
Totterdown Hall, Walton-on-Thames ...	1	1
St. Raphael's, Barwin Park, Herts. ...	1	1
House of Help, Bath	1	1
Stanley Hospital, Ulverston	1	1
Under the jurisdiction of the Board of Control:-		
Rampton Hospital, Retford, Notts ...	3	3
Moss Side Hospital, Maghull, Liverpool ...	5	3
	340	300

It will be noted that there was a considerable increase in the number of patients placed under institutional conditions and receiving that degree of care, control and training which in certain cases can only properly be effected by admission to hospital. The net increase of forty defectives in institutions was principally due to the opening of two new wards at Dovenby Hall Hospital. Indeed of the 43 cases newly admitted to institutional care during the year, 40 were admitted to Dovenby, 1 to Prudhoe and Monkton Hospital and 2 to Aycliff Hospital. Two patients died in institutions during the year, and one was discharged from order under the Mental Deficiency Acts.

Before making specific comment on the hospital position for defectives, both locally and nationally, the

" waiting list " position must be considered in conjunction with the table shown above. The following table analyses the waiting list at the end of 1954, the corresponding figures for 1953 being shown in brackets. It will be seen that the table is divided into two main groups (" urgent " and " non-urgent ") to comply with the Ministry's statistical requirements. As I have pointed out in the past, the degree of urgency in particular cases varies over a wide range. The situation as regards any individual on the list may change very rapidly because of domestic changes or crises within the patient's home, which may make what was regarded as " non-urgent " a case of extreme urgency more or less overnight, but I should explain that in dividing the total waiting list into two arbitrary groups, the " urgent " group has been reduced to the smallest possible proportions.

	Under 16	16 years and over	Total
1. In urgent need of institutional care			
(a) Cot and chair cases	2 (8)	— (—)	2 (8)
(b) Ambulant and low grade cases ...	5 (12)	2 (3)	7 (15)
(c) Medium grade cases	3 (19)	3 (7)	6 (26)
(d) High grade cases	— (1)	1 (5)	1 (6)
	10 (40)	6 (15)	16 (55)
2. Not in urgent need of institutional care			
(a) Cot and chair cases	2 (2)	— (1)	2 (3)
(b) Ambulant low grade cases ...	2 (6)	3 (11)	5 (17)
(c) Medium grade cases	10 (7)	7 (18)	17 (25)
(d) High grade cases	— (2)	5 (6)	5 (8)
	24 (57)	21 (51)	45(108)

It is pleasing to note the considerable reduction in the total number of patients on the waiting list for admission to mental deficiency hospitals, and in particular to note that the " urgent " list was reduced from 55 at the end of 1953 to 16 by the end of 1954. Locally, then, we can say that rather more than two-thirds of our most difficult problems have been dealt with as a result of the opening of additional accommodation at Dovenby Hall Hospital. What this means to those who

have had to cope with low grade or anti-social defectives in their own homes—in some cases for years—can only be fully appreciated by those who have had intimate and regular contact with such cases. Whilst appreciating the greatly improved situation, we must, I feel, regard this as merely a temporary amelioration of a truly distressing situation, and we cannot afford to be in any way complacent about the present position.

No local health authority mental deficiency service can be regarded as efficient until the hospital service, with which it is inextricably linked, is able to supply hospital accommodation completely adequate to the needs of the local domiciliary service. Two essential facts remain and must be constantly in our minds—

(1) The *duty* of the local health authority is clearly defined in the Mental Deficiency Act of 1913 as follows :—

> "to provide suitable supervision. . . . or if such supervision affords insufficient protection, to take steps for securing that they. . . be dealt with by being sent to institutions or placed under guardianship. . . ."

I venture to suggest that no local health authority, and certainly not Cumberland, is in a position, because of the shortage of accommodation in mental deficiency hospitals to carry out these statutory duties. The fact that there are waiting lists is evidence that beds are not freely available. This produces the rather Gilbertian situation where the Ministry of Health may with-hold the grant payable to a local health authority in respect of its mental health service on the grounds that it is failing in its statutory duties, when that failure springs from the fact that adequate hospital accommodation (for the supply of which the Ministry is responsible) is not available.

(2) Although this year, for the first time for many years, we are able to record a reduction in the waiting list, we have in fact merely reduced the list to the level of four years ago. In 1950 the waiting list stood at 45, and reached its peak of 108 by the end of 1953, so that at present our

waiting list position is no better than it was four years ago, but at least shows considerable improvement by comparison with last year. We must not forget that the main hospital on which we can call for beds is now full in spite of the recent useful increase in its total accommodation. In the meantime the ascertainment of defectives continues at a steady pace and many of our guardianship cases will inevitably find their names included on the waiting list for institutional care in the not too distant future, so that in all we can expect the size of our waiting lists to increase from year to year until additional and adequately staffed hospital accommodation becomes available in satisfactory proportions.

In general the position in Cumberland is merely a reflection of the situation as it exists throughout England and Wales. According to the latest national figures which are available, there were 8,442 defectives on the waiting lists throughout England and Wales at the end of 1953. This number is very slightly less than the corresponding figure for the previous year, but still remains more than double the figure for 1948. This problem of increasing shortage of beds is linked with the problem of staffing. At the end of 1953, there were 1,750 beds available in mental deficiency hospitals which could not be used because nursing staff could not be found and since 1948 there has been a *decrease* in the number of student mental and mental deficiency nurses of about 25 per cent. in comparison with an *increase* of almost the same percentage in all other types of hospitals. We know that the Ministry, through its Regional Hospital Boards, is doing what it can so far as financial and supply difficulties permit to provide the beds which are so desperately needed, and that nursing recruitment publicity is being primarily devoted so far as the Ministry of Labour is concerned, to recruitment for mental and mental deficiency hospitals. Our duty as a local health authority, therefore, is to adapt our local service to meet so far as we can the situation created by this inadequacy of hospital facilities for defectives.

REPORTS AND NOTES ON INDIVIDUAL SERVICES AND OTHER MATTERS

Dental Service

Orthopaedics

Prevention of Blindness

Spastics and Epileptics

Venereal Disease

Cancer

Infectious Diseases

Food and Milk

Housing

Water and Sewerage

DENTAL SERVICE

The Senior Dental Officer makes the following comments on the dental service for 1954:-

"In previous years it was usual to leave staffing matters to the end of annual reports, as all that was required was a note of any who had left the service and of those who had replaced them, as any vacancy always attracted a fair number of applications. Now, however, staffing takes precedence in view of the difficulty to obtain even one application for a vacancy. One authority now goes in for displayed advertisements setting out the various advantages offered in their employment, so that the time may come when Cumberland will need to set forth the many benefits of residence in the Lake District in addition to the usual details as to terms and conditions. All this leads up to the unfortunate fact that—while Mr. F. H. Jacobs has been appointed to fill the post vacated by Mrs. Ferguson — in spite of repeated advertisements no successor has been found for Mr. Askew.

"There is, of course, no prospect of filling the further appointment which had been authorised for October 1954. As a result there has still been no attempt to organise treatment of pre-school cases on *routine* lines. As has been emphasised often, "under fives" can take up a lot of time without much apparent result, as most of it is spent in training the patient and, in some cases, the parent as well. As a long term policy such time is well spent, as it forms a basis for treatment later on, but at the moment time is not available to invest for the future, there is not sufficient available to meet present needs. For the present, treatment is available to all who seek it, while quite a few cases are referred by health visitors and district nurses. The results are given in the table of treatment carried out.

"With regard to expectant and nursing mothers, there would appear to be an increase. Forms were sent to about one thousand cases and a few short of three hundred were returned which is a decided improvement. but of these over fifty failed to keep appointments and a few had private treatment. Of course, there are always those cases who ask to be supplied with dentures after their teeth have been extracted by a private

practitioner. This is for one reason only—they do not wish to pay the charges under the National Health Service. These cases are always refused as long as there is a contract with the dentist through the Executive Council. It is to the credit of the profession that in quite a few instances the dentist concerned has voluntarily withdrawn from the case and written to say so, thus depriving himself of the work but allowing the patient the benefit of free treatment. It is quite evident that many expectant mothers are not aware of the financial position, though it appears that the provisions are gradually becoming known with the resulting increase in the number of cases referred to above."

Numbers provided with dental care.

	Examined.	Needing Treatment.	Treated.	Made Dentally Fit.
Expectant and Nursing Mothers ...	277	266	260	255
Children under five	251	239	239	99

Forms of dental treatment provided.

	Scalings & Gum treatment.	Fillings	Silver Nitrate treatment.	Crowns or Inlays	Extractions	Dentures provided: Gen. Anaesthetics	Dentures provided: Full Upper or Lower	Dentures provided: Partial Upper or Lower	Radiographs.
Expectant & Nursing Mothers	17	96	—	—	1221	84	97	38	15
Children under Five	—	48	30	—	561	173	—	—	—

ORTHOPAEDIC TREATMENT

The statistics for 1954, which follow, do not differ materially from those of the previous year. In the matter of the follow-up and aftercare of patients on discharge from hospital, or in respect of the supervision of patients temporarily sent out in plaster, there has been, during the year, a welcome and quite substantial increase in the work undertaken at the county orthopaedic clinics, through increasing and very welcome co-operation with one of the consultant orthopaedic surgeons.

I should very much like to see this aspect of the work increase, because, with two trained orthopaedic physiotherapists on the county staff, both provided with motor transport, we could do quite a lot in helping the hospitals by keeping an eye on patients discharged—either at the conclusion of treatment, or at an interim stage, in respect of plasters or appliances in particular. We could I think, as I have said before, help to save West Cumberland patients who have received hospital treatment in Carlisle, long journeys for review. Also, as I have said before, the two types of clinics—hospital and county—should run in co-operation and not in competition, and the county clinics should ease the crowded hospital out-patient clinics.

The early treatment of congenital deformities in babies, such as club feet, wry-neck, etc., through our county orthopaedic service with the co-operation of the general practitioners and the midwives, is increasing quite substantially. This early treatment of certain congenital orthopaedic defects is, of course, of the first importance.

Orthopaedic conditions affecting children under five years of age

Bow leg and knock knee	188
Flat foot	50
Congenital defects of feet and otherwise ...	31
Poliomyelitis	7
Torticollis	7
Cerebral palsy	7
Congenital dislocation of the hip	5
Birth palsy	4
Scoliosis, lordosis and kyphosis	15
Postural defects, feet and otherwise	33
Injuries, including fractures	2
Other conditions	16
Minor conditions seen by physiotherapists only	171
	536

Tuberculosis of bones and joints

	Adults	School children	Under 5 yrs.
Totals	85 ...	29 ...	3

Adult non-tubercular cases

Poliomyelitis	21
Arthritis	9
Scoliosis, lordosis and kyphosis	2
Congenital dislocation of the hip	13
Slipped epiphysis	3
Flat foot	6
Osteomyelitis	10
Vertebral disc protrusion	20
Hallux valgus, and deformed toes	6
Injuries, including fractures	11
Cerebral palsy	4
Congenital defects	12
Postural defects, feet and otherwise	2
Perthes disease	4
Synovitis and other joint conditions	5
Other conditions	4
	132

General statistics

Number on aftercare register, 1/1/54	745
New cases during 1954	243
New cases notified for physiotherapist only	91
Cases re-notified after previous discharge	4
Number of cases removed from register	236
Number remaining on register at 31/12/54	756
Number of attendances at surgeons' clinics	723
Number of attendances at aftercare clinics	1687
X-ray examinations during 1954	84
Waiting for X-ray	53
Home visits	358
Plasters applied	39
Surgical boots and appliances supplied (including insoles)	226

Hospital admissions

Name of Hospital.	In hospital at 1/1/54.	Admitted during year.	Discharged.	In at 31/12/54.
Ethel Hedley Hospital, Windermere (including school children).	13	32	33	12
Shropshire Orthopaedic Hospital, Oswestry (in addition to these long stay cases 17 patients were admitted and discharged after short-stay review).	6	3	8	1
Cumberland Infirmary, Carlisle (including school children)	—	28	28	—

The above figures refer only to patients admitted to hospitals from our county clinic waiting lists. I have no information about other hospital admissions or waiting lists.

PREVENTION OF BLINDNESS AND CARE AND AFTERCARE OF BLIND OR PARTIALLY SIGHTED PERSONS

The welfare of the blind is dealt with each year in detail by the County Welfare Officer in his section of this report. No material change has taken place over the past year, except that it may be worth noting that a new form B.D.8 has been issued by the Ministry for the registration of blind or partially sighted persons. This new form for the first time has a special section dealing with blind or partially sighted children.

The following table which follows the lines desired by the Ministry shows the position in the county for 1954:—

A. Follow-up of Registered Blind and Partially Sighted Persons.

	Cause of Disability.			
	Cataract.	Glaucoma.	Retrolental Fibroplasia.	Others
(i) Number of cases registered during the year in respect of which para. 7(c) of Form B.D.8 recommends:-				
(a) No treatment	24	9	—	45
(b) Treatment (medical, surgical or optical)	17	9	—	17
(ii) Number of cases at (i)(b) above which on follow-up action have received treatment	5	4	—	1

B. Ophthalmia neonatorum.

(i) Total number of cases notified during the year	Nil
(ii) Number of cases in which:-	
(a) Vision lost ... ...)	
(b) Vision impaired ... ...)	Nil
(c) Treatment continuing at end of year)	

This is the second successive year in which no cases of ophthalmia neonatorum have been notified and this condition, which used to lead to tragic results, has now for all practical purposes ceased to exist.

SPASTICS AND EPILEPTICS

Last year the Ministry asked for information regarding the incidence of the above conditions in the area. The matter has got a little further since then and we are now in a position to give some more up to date information, which as regards spastics may be regarded I think as fairly complete. The following table shows the number of spastic children of school age in the county.

Number of spastic children of school age in Cumberland, divided into the following groups—31.

(a) Attending ordinary schools ... ... (One girl attends half-time).	14
(b) At special residential schools ... ... (One other boy was removed during the year and now falls under (f)).	2
(c) Attending residential schools for educationally sub-normal children ... ... (One boy at Ingwell, one girl at Birmingham).	2
(d) Awaiting admission to residential schools ... (Three are awaiting short term admission for investigation. Of the above seven, two are receiving home tuition, four are neither attending school nor having home tuition).	7
(e) Classified as ineducable ... ... (One is attending an occupation centre).	3
(f) Having home tuition	2
(g) Not attending school or having home tuition ...	1
	31

There are 7 spastic children under school age known to us, and although the position about adolescent and adult spastics is very difficult indeed to ascertain accurately, there appear to be in the county 21 adolescent or adult spastics suffering from severe or fairly severe disability, none of whom appear, so far as is known, to be severely mentally handicapped. There are in addition quite a number of mild adolescent or adult spastics, all of whom appear to be living a comparatively normal life and most of whom are in employment.

Epileptics

We have compiled a register which we fully realise is quite incomplete, of epileptics in the county. The figure at the moment stands at 71. This includes epileptics of all ages.

The Welfare Department maintain at present 4 men and 3 women at epileptic colonies and 5 men and 2 women are maintained in Part III accommodation in the county. The Education Department maintain a few epileptic children in epileptic colonies or schools.

VENEREAL DISEASES

I am indebted to Dr. H. J. Bell, Consultant Venereologist for the following extracts from his report to the Special Area Committee. After reviewing the new infections and total attendances over a period of years, Dr. Bell makes these comments:—

"The fall in numbers of total attendances can be accepted as an index in reduction of work at the clinics. It will be readily noted that this is about 50 per cent. since 1950. It is accounted for not only by the reduced incidence of early syphilis, but much more so by the increasing interest of general practitioners and their willingness to treat their own patients under the guidance of the consultant. As has been pointed out before in this report, the official V.D. clinics have tended to change their original function as treatment centres and to become diagnostic centres.

"These days, the work of the venereologist is mainly taken up with patients suffering from neuro-syphilis, and other types of late syphilis. This is an inheritance from the war years and these cases will be on the increase for some years to come, as they are at the moment.

"As far as numerical superiority is concerned, the commonest conditions for diagnosis and treatment are non-venereal. Non-gonococcal urethritis still remains more common than male gonorrhoea. Recent research has failed to shed any further light on this problem. As pointed out in last year's report, the disease is readily curable, although its aetiology remains a mystery.

"It is interesting to compare our situation with the overall picture for England and Wales:—

	1953	1954
Primary Syphilis (Male & Female) ...	503	414
Secondary Syphilis (Male & Female) ...	264	190
Gonorrhoea (Male)	15,258	13,953
Non-gonococcal Urethritis (Male) ...	13,095	13,250
Gonorrhoea (Female)	3,973	3,558

"Here, again, is shown the continuing and marked decline in morbidity of early syphilis, the similar decline in male gonorrhoea and the increase in non-specifiic urethritis. The figure for female gonorrhoea, which has been on the increase in recent years, has fallen away a little in 1954.

Congenital Syphilis

"No case of neonatal syphilis was discovered during 1954. Under the County Council scheme for Rhesus and Wassermann testing, some 722 sera were submitted to the Pathological Department, revealing thereby five pregnant women with positive Wassermann blood re-actions. In addition, four women were referred from hospital ante-natal clinics. Four fresh cases of congenital lues came under treatment for the first time, two were children, and two were adults."

CANCER

Deaths from cancer during the year amounted to 354, approximately the same figure as for the previous year. Details of these deaths by age groups and sanitary districts are given below.

Cancer Deaths during 1954—By Sanitary Districts

	Males	Females	Total
Urban Districts :			
Cockermouth	3	8	11
Keswick	4	6	10
Maryport	13	9	22
Penrith	3	10	13
Whitehaven	19	15	34
Workington	38	27	65
Aggregate of Urban Districts	80	75	155
Rural Districts :			
Alston	3	3	6
Border	18	30	48
Cockermouth	14	9	23
Ennerdale	21	23	44
Millom	9	12	21
Penrith	9	8	17
Wigton	23	17	40
Aggregate of Rural Districts	97	102	199
Whole County ...	177	177	354

Cancer Deaths during 1954—By Age Groups.

	0-45		45-65		65+		All Ages Totals	
	M.	F.	M.	F.	M.	F.	M.	F.
Urban Districts ...	3	6	26	21	51	48	80	75
Rural Districts ...	8	2	30	47	59	53	97	102
Whole County ...	11	8	56	68	110	101	177	177
	19		124		211		354	

As a matter of interest I looked up some of my predecessor's reports of many years ago and I see that 30 years ago the number of recorded deaths from cancer was 227. This would seem, relative to our figures of deaths from cancer in recent years, to indicate that there has been a marked increase in the incidence. I think with one notable exception that the probable reasons is, in the main, improved diagnosis. It is, of course, common knowledge that diagnosed cases of cancer of the lung and bronchus are on the increase. This as you know has been ascribed by some to increased smoking, particularly of cigarettes, by others to chemical fumes in the air of towns due to exhaust fumes from motor cars, etc. I merely mention this because I have been asked by the Medical Research Council, along no doubt with other medical officers of health, to provide statistics about the incidence of cancer of the lung and bronchus in rural as opposed to urban areas over the past few years. We are, of course, glad to make our small contribution to this investigation.

The hospital side of this matter is entirely one for the Special Area Committee. Our part as a health authority is confined to the provision of domiciliary nursing, domestic help, and after-care, under Section 28 of the Act. We are, of course, also responsible for transport.

I am indebted to the secretary of the East Cumberland Hospital Management Committee for the following figures relative to the out-patient clinics and hospital admissions at the Cumberland Infirmary. It will be noted that these figures include figures for areas outside the administrative county:—

Patients Attending Out-Patient Clinics

	First Attendance	Other Attendances	Totals
County	174 ...	834 ...	1,008
City	124 ...	564 ...	688
Other Districts ...	47 ...	234 ...	281
Totals	345 ...	1.632 ...	1,977

Patients Attending Out-Patient Clinics

County	212
City	120
Other Districts	52
	384

During 1954, 513 patients were *registered* as new cancer cases, of which 286 are known to be from the County of Cumberland. It should be noted that a considerable number of Whitehaven and district patients are followed up at the clinics in West Cumberland. It has been noted also, on compiling these figures, that many patients have their first attendance as in-patients and are followed up elsewhere—frequently in West Cumberland.

INFECTIOUS DISEASES

No major epidemics of infectious disease occurred during the year. There were, of course, as usual, a large number of cases of measles and whooping cough, the former being especially prevalent in Whitehaven Borough and Ennerdale Rural District, and the latter in Ennerdale and Millom Rural Districts. There were unfortunately two cases of measles and one of whooping cough which terminated fatally.

Only nine cases of poliomyelitis were notified of whom four were of the non-paralytic type.

There were no cases of diagnosed or suspected smallpox and no case was notified in the enteric fever and allied groups. There were no notified cases of diphtheria. We have not, in fact, had any notified cases of diphtheria in the past three years. One case of malaria was notified during the year.

The records of mortality from the commoner infectious diseases in respect of the past few years are as under:—

1945/1953 inclusive ...	Scarlet Fever ...	nil
1954		Nil
1945/1953 inclusive ...	Diphtheria	5
1954		Nil
1945/1953 inclusive ...	Enteric Fever ...	1
1954		Nil
1945/1953 inclusive ...	Measles	20
1954		2
1945/1953 inclusive ...	Whooping Cough ...	27
1954		1
1945/1953 inclusive ...	Diarrhoea (including gastritis and enteritis)	102
1954		5

The new West Cumberland Hospital when completed will have an infectious diseases block of some 20 beds. This will obviously be designed on the cubicle system, and, together with the available accommodation at the isolation block at the Cumberland Infirmary, should enable the hospital authorities to deal with any epidemic likely on present experience to arise.

The following table shows the incidence of infectious diseases in the County during 1954.

NOTIFICATION OF CASES OF INFECTIOUS DISEASES IN THE COUNTY OF CUMBERLAND DURING THE YEAR 1954

District.	Scarlet Fever.	Whooping Cough.	Dip.	Measles.	Pneumonia.	Meningococcal Infection.	Acute poliomyelitis Paralytic.	Acute poliomyelitis Non-paralytic.	Acute encephalitis Infective.	Acute encephalitis Post-infectious.	Dysentery.	Food Poisoning.	Erysipelas.	Chicken Pox.	Malaria
Urban Districts															
Workington ...	24	91	—	138	17	3	3	2	—	1	—	—	21	224	—
Whitehaven ..	12	48	—	852	13	—	—	1	—	—	—	—	4	1	—
Cockermouth .	3	5	—	1	1	1	—	—	—	—	—	—	—	—	—
Keswick	—	3	—	—	—	—	—	—	—	—	—	—	—	—	—
Maryport ...	19	33	—	19	5	—	—	—	—	—	—	2	—	—	—
Penrith	5	81	—	104	4	—	—	—	—	—	19	—	2	—	—
Rural Districts															
Alston	2	5	—	62	5	—	—	—	—	—	—	—	1	8	—
Border	18	21	—	232	13	4	1	1	—	—	4	1	3	—	1
Cockermouth .	18	24	—	108	12	—	—	—	—	—	—	—	1	—	—
Ennerdale ...	10	210	—	1,020	6	1	1	—	—	—	—	—	3	—	—
Millom	2	161	—	56	12	1	—	—	1	—	—	1	3	—	—
Penrith	10	27	—	128	9	—	—	—	—	—	—	—	1	—	—
Wigton .....,	11	37	—	170	8	2	—	—	—	—	—	—	2	—	—
TOTALS ...	134	746	—	2890	105	12	5	4	1	1	23	4	41	233	1
1953 ...	204	702	—	2846	130	11	9	21	1	—	5	13	45	264	—
1952 ...	278	388	—	662	79	9	9	3	—	—	45	7	39	115	—
1951 ...	240	679	2	4616	139	17	24	10	2	—	89	10	44	348	—

INSPECTION AND SUPERVISION OF FOOD

Foods other than Milk

The report of the County Analyst is not included as this has already been circulated to the County Council. No epidemic of food poisoning of any significance occurred in the county during the year under review.

Milk

At the end of October this year, the County of Cumberland, together with parts of certain adjoining counties becomes an "Attested Area," being the first substantial area in England to be so graded. I have in previous reports commented on this satisfactory position, which reflects credit on the intensive efforts of the former Milk Committee of the Cumberland County Council to eradicate tubercle from the milk supply, on the Divisional Veterinary Inspector of the Ministry of Agriculture and his staff and on the farming community. The incidence of non-pulmonary tuberculosis in the county which, of course, is generally attributable to tuberculous milk, has been steadily and indeed rapidly declining in recent years.

Perhaps one proof of this is that, whereas a number of years ago we used as a county council to maintain anything up to 25 cases of tuberculosis of the spine or other bones or joints at the Shropshire Orthopaedic Hospital, Oswestry, and also a considerable number of children with similar conditions at the Ethel Hedley Hospital, Windermere, the position has now completely changed. For example, we only sent one new case of bone and joint tuberculosis to the Shropshire Hospital from the county last year, and in respect of the Ethel Hedley Hospital similarly only four new cases among children. It is, one would venture to prophesy, not too much to hope that, in the years ahead, tuberculosis of bovine origin will become a rarity in the county.

As you know, on the transfer of responsibility for the bacteriological cleanliness of the milk supply to the Ministry of Agriculture, the County Council decided to continue milk sampling for tubercle in respect of ungraded milks consumed in Cumberland without pasteurisation. It has now been decided that as from the end of October, for the reasons given above, this sampling is no longer necessary and will be dis-

continued. The actual figures for sampling undertaken during 1954 were as follows, the figures for 1953 being included for comparison:—

Number taken for biological examination for tubercle

Sanitary District	1954	1953
Rural		
Alston	—	—
Border	1	—
Cockermouth	195	181
Ennerdale	51	48
Millom	128	175
Penrith	—	26
Wigton	148	218
	523	648
Urban		
Cockermouth	—	—
Keswick	3	3
Maryport	11	16
Penrith	—	—
Boroughs		
Whitehaven	2	11
Workington	—	10
	539	688

As will be seen, a very large proportion of the samples taken relate to three rural districts. During 1953, out of the 688 samples taken, not one was found positive for tubercle. During 1954, out of 539 samples, one was found positive for tubercle by guinea pig inoculation. The source of infection was traced and the animal slaughtered.

Once more I have to express my indebtedness to the Divisional Inspector of the Ministry of Agriculture for his close co-operation with this department. The figures which follow, and which he has been good enough to send me, deal with the clinical inspection and tuberculin testing of dairy herds. The figures for 1953 are given in brackets for comparison:—

Clinical Inspection of Dairy Herds

Class of Herd	No. of Herd Inspections	No. of Cattle examined	Cattle dealt with under the Tuberculosis Order
Tuberculin Tested	1,349 (1,152)	66,927 (59,100)	—
Accredited	6 (21)	254 (938)	1
Non-Designated	4,337 (2,867)	86,631 (60,173)	14

Tuberculin Testing of Tuberculin Tested Herds.

No. of cattle tested	112,423	(79,304)
No. of reactors	221	(129)

Tuberculosis (Attested Herds) Scheme.

No. of attested herds	4,628	(3,810)
No. of supervised herds	105	(66)

Pasteurised Milk

At the end of the year, there were still only three pasteurising plants in the administrative county, one in Egremont and two in Millom. During the early months of 1955 another pasteurising plant has come into operation in Wigton. As before, our sampling duties in respect of pasteurised milk have been carried out through the co-operation of the sanitary inspectors of the district councils concerned, for which co-operation we are grateful.

Seventy-seven samples were taken during the year and submitted to the phosphatase and methylene blue tests. Of these, sixty-eight were satisfactory to both tests and nine unsatisfactory (eight to the phosphatase test and one to the methylene blue test).

HOUSING

The two schedules which follow are full of interest. The first schedule sets out the general housing situation in the administrative county. Comparisons with the figures for 1953 raise some points of interest. For example, although the figures are not available for all the housing authority areas in the county, they show that the estimated number of houses which are unfit for habitation and cannot be made fit at a reasonable cost has fallen from a total of 5,882 in 1953 to 4,748 in 1954. The estimated number of sub-standard houses which could be repaired and made fit has fallen from 10,906 in 1953 to 9,406 in 1954, which represents a fall of some 800 houses in the County total after making an appropriate allowance for areas for which figures are not available. This might appear to mean that a substantial number of sub-standard houses have been rehabilitated under the provisions of the Housing Repairs and Rents Act, but the figures under Section D of the schedule only bear this out in part.

The second schedule, which I am permitted to include in this report through the courtesy of the clerks to the housing authorities in the county, was compiled by Mr. Marwood, the honorary secretary of the Cumberland Old People's Welfare Committee as a result of enquiries issued at the request of the committee to housing authorities in the county, asking for particulars of the provision made or proposed to be made in their housing programmes, for providing dwelling houses for old people. Adding up the figures on these returns shows that a total of 479 houses, bungalows, or flats for old people have been specifically erected by the housing authorities in the county. These are mostly of the one or two bedroom type, and generally are not segregated but are mixed in the general housing schemes. One would have thought that, particularly in the larger urban areas, segregation of old people's bungalows or flats would have been an advantage. It would clearly make the serving of a hot midday meal from some centre more easy and would also facilitate help from the nursing and home help services, in addition to providing a community of interest.

HOUSING RETURNS FOR THE COUNTY OF CUMBERLAND
FOR
YEAR ENDED 31st DECEMBER, 1954.

	Alston R.D.C.	Border R.D.C.	Cockermouth R.D.C.	Ennerdale R.D.C.	Millom R.D.C.	Penrith R.D.C.	Wigton R.D.C.	Total for R.D.C's in County	Whitehaven Borough	Workington Borough	Cockermouth U.D.C.	Keswick U.D.C.	Maryport U.D.C.	Penrith U.D.C.
Population 1931	2678	26049	21250	28235	12582	12016	22068	124868		24751	4784	4635	10190	9065
1951	2327	29848	19560	29651	13428	11720	23733	130247	24624	28882	5234	4660	12180	10490
A. 1—Total number of occupied dwelling houses in the district	881	7957	5968	8737	4298	3466	7177	38484	—	8456	1934	1608	3958	3132
2—Total number of occupied dwelling houses subject to Demolition Orders, Closing Orders or Undertakings	—	62	40	65	1	—	26	194	91	49	47	1	151	4
3—Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost	170	590	94	1872	88	230	347	3391	480	340	N.A.	20	267	250
4—Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit	380	950	1850	3197	498	750	1478	9103	N.A.	—	N.A.	100	153	150
5—Number of houses found to be overcrowded	30	47	—	22	14	150	17	280	—	—	N.A.	—	—	26
B. WAITING LISTS. Total number of valid applicants on Council's waiting list exclusive of those living in houses under A2 and 3 above	20	803	165	292	189	—	459	1928	—	1263	145	165	256	150
C. NEW HOUSES COMPLETED DURING THE YEAR. 1—By or for the Council—														
For aged persons	—	1	4	8	—	—	—	13	4	—	—	—	30	—
For agricultural workers	—	1	—	4	—	1	10	16	—	—	—	—	—	—
Flats	—	1	—	20	—	—	—	21	—	12	—	—	—	—
General purpose houses	8	79	78	187	31	45	76	504	206	249	20	20	20	22
2—Private building	2	50	30	7	7	8	24	128	12	114	7	9	—	10
Total	10	132	112	226	38	54	110	682	222	375	27	29	50	32
D. 1—Number of houses for which application was made by private persons for Improvement Grants under the Housing Act, 1949	2	29	22	7	24	29	32	145	—	—	1	—	—	6
2—Number of houses for which grants were approved	2	29	20	2	21	24	28	126	—	—	1	—	—	6
3—Number of houses where improvements were carried out and grants paid	—	16	14	1	3	5	11	50	—	—	—	—	—	2
4—Number of houses purchased or taken over by the Council with a view to improvement or conversion	—	13	—	—	4	—	—	17	—	—	—	—	—	1
5—Number of houses improved by the Council— (i) With grant	—	—	3	—	—	—	—	3	—	—	—	—	—	—
(ii) Without grant	—	—	—	—	3	—	—	3	—	—	—	—	—	—
E. TEMPORARY ACCOMMODATION. Number of families occupying camps and temporary buildings	—	66	—	—	—	—	41	107	—	—	8	—	—	74
F. HOUSING PROGRAMME. Estimated number of houses to be built during the ensuing year														
(i) Private	—	NK	30	10	9	20	16	85	15	20	12	10	2	15
(ii) Council	39	80	80	50	67	24	88	428	270	200	82	28	88	88

CUMBERLAND OLD PEOPLE'S WELFARE COMMITTEE

SCHEDULE OF REPLIES RECEIVED TO QUESTIONNAIRE AS TO HOUSING OF THE OLD PEOPLE

Authority (1)	Number of Council Houses (2)	Number of Aged Persons Houses (3)	Are Special Facitities Provided (4)	Are Aged Persons Houses Segregated or Mixed with the Ordinary Schemes. (5)	Is a Specially Reduced or Uneconomic Rent Charged (6)	Other Remarks (7)
Whitehaven Corporation	3,800	36 Bungalows 85 Flats	Community Centre	Flats are in pre-war housing schemes. Bungalows on fringe of post-war schemes.	Yes	More bungalows to be included in further contracts.
Workington Corporation	2,352	60 Flats	No	Segregated but in future to be mixed with general housing development.	Yes	—
Cockermouth Urban District Council	507	12 Bungalows	No	Mixed with the ordinary schemes.	Yes	Provision for further Aged Person bungalows is contemplated.
Keswick Urban District Council	243	10 Flats 8 (2 bedrooms) 2 (1 bedroom)	No	Mixed in the ordinary housing scheme.	Yes	—
Maryport Urban District Council	1,335 (Including houses erected by † the N.E.H.A.)	103 Bungalows 40 (1 bedroom) 63 (2 bedrooms)	No	Mixed in the ordinary housing scheme.	No	—
Penrith Urban District Council	800	20 Houses 4 Bungalows	No	Mixed in the ordinary housing scheme.	Yes	50-60 will probably be built including 24 in process of erection.
Alston with Garrigill Rural District Council	128	24 Flats (1 bedroom) 16 Alston 8 Nenthead	No	Mixed in the ordinary housing scheme.	No	Full Exchequor & Rate Fund Subsidy paid on the houses thus no reduced rent is charged. County Council is being approached re Hot Meals for Old People from the School Canteen.
Border Rural District Council	680	Nil	Not yet considered	Not yet considered.	Not yet considered	Council are considering both building aged persons houses and converting existing properties into small houses.
Cockermouth Rural District Council	1,164 (Including N.E.H.A. houses) †	26 Bungalows 2 Crosscanonby 2 Dearham 10 Seaton 2 Brigham 4 Broughton 4 Great Clifton 2 Broughton Moor	No	Mixed in the ordinary housing scheme.	Yes (on N.E.H.A. estate)	Where houses are built in any numbers the Council's policy is to provide approx. 10% as Bungalows. At Great Clifton there are four houses in the process of being built. Broughton Moor — next year?
Ennerdale Rural District Council	2,565 1,435 N.E.H.A. 1,130 E.R.D.C.	20 Bungalows 40 Flats 16 Flats (Parton) 8 Flats 12 Bungalows (Egremont) 16 Flats 8 Bungalows (Cleator Moor)	No	Mixed in the ordinary housing scheme.	A reduced rent which is higher for post-war houses than pre-war ones	Four bungalows are to be erected at Frizington.
Millom Rural District Council	504 240 N.E.H.A. 264 M.R.D.C.	Nil	No	To be mixed in housing scheme when erected.	Not yet known.	Eight bungalows for old persons are included in future developments.
Penrith Rural District Council	—	—	—	—	—	This Council have not built houses suitable for old people; there has been no demand for such to be erected; the Penrith Rural Area being predominantly agricultural.
Wigton Rural District Council	1,087	39 Bungalows 30 Wigton (1 bedroom) 6 Aspatria (1 bedroom) 3 Silloth (1 bedroom)	No	Mixed in the ordinary housing scheme.	Subsidised Rents Wigton — 7/1d. per week. Erected pre-war. Aspatria — 7/7d. Erected pre-war. Silloth — 11/10d. Erected post-war. All include rates.	It is proposed to build additional old people's houses at Aspatria and Wigton. Present rates are to be reviewed in the near future.

† N.E.H.A. North Eastern Housing Association.

With regard to housing plans for County Council employees I am indebted to the County Architect for the notes which follow:—

"Houses for district nurses, firemen, police officers, and school caretakers, have been provided during the year, the total number completed being 28, while 10 were under construction at the end of the year.

"Prices have continued to increase somewhat, although the rise has not been so marked as in previous years. The price of houses varies greatly according to the district in which they are to be erected, the cost of a house in West Cumberland being almost 20 per cent. higher than in the Carlisle area.

Fire Service

"Epworth House, Penrith, has been converted into three flats and two houses at Dalston have been completed. The ten houses adjoining Hensingham Fire Station are nearing completion.

Police Service

"Twenty houses were completed during the year and it is anticipated that about 36 houses will be commenced during the present year, in addition Hunter House at Penrith will be converted into three houses.

Nursing Service

"Four houses were completed during the past year and four more will be commenced this year. These four will have an increased area over last year's houses of about 10 per cent., extra storage accommodation having been provided in addition to a larger entrance hall, landing, kitchen and surgery. The bathroom will be on the first floor in place of the ground floor as in last year's type.

Education

"A caretaker's house at Netherhall School, Maryport, and a caretaker's bungalow at Workington Grammar School were completed during the year."

WATER AND SEWERAGE SCHEMES

Schemes in varying stages of progress for the improvement of water supplies have been considered by the County Council from almost every rural district council in the county during the past year, and, by comparison, only two schemes for sewerage and sewage disposal have been dealt with.

The indication is that the district councils are pressing forward with their plans for improvement of water supplies, which no doubt had in many cases been held in abeyance in expectation of the benefits of the North Cumberland Water Board's Caldewhead scheme.

It is gratifying to note this improvement of water supplies, and doubtless when there is an adequate supply available schemes for the sewering of many of the rural areas of the county will follow.

Unfortunately some schemes, although approved in principle by the Ministry, have not been allowed to proceed owing to the curtailment of capital expenditure.

It is interesting to note from a summary of grants made by the County Council under the Rural Water Supplies and Sewerage Act, 1944, and earlier acts that of a total capital expenditure of £975,000 on 115 sewerage and water supply schemes the council have approved grants equivalent to £165,000. Prior to the war, the council's assistance was for the most part by way of capital contributions from revenue. In view of the number of schemes coming forward since the war, the policy has been to make to district councils annual grants for the period of the loans raised—usually 30 years—and the Rural Water Supplies and Sewerage Act, 1955, enables the government to make grants either by lump sum or by periodical payments. In practice, lump sum grants will continue to be made from government funds where the grant on this basis does not exceed £2,000.

Other information from the summary is as follows:—

	No. of Schemes	Total Capital Cost	County Council Grant Aid
		£	£
Schemes completed prior to war	81	449,700	80,209
Schemes approved since 1/4/1947 where the County Council have fixed the amount of their grant—			
Completed schemes ..	23	152,200	35,200
Other approved schemes at various stages ...	11	373,300	50,200
Total	115	£975,200	£165,600
Analysis:—			
Sewerage schemes	76	£523,000	£97,900
Water schemes	39	£452,200	£67,700
	115	£975,200	£165,600

Appendix "A" hereto shows the water schemes, and Appendix "B" the sewerage schemes, considered during the year.

APPENDIX "A"

Scheme submitted by	Name of Scheme	General Outline	Estimated or Final Cost	Grants Ministry	Grants County	Remarks	Stage at 31st March, 1955
			£	£	£		
Alston-with-Garrigill R.D.C.	Comprehensive Water Supply Scheme.		109,000	50,000	45,000	Postponed indefinitely.	
do.	The Raise Water Supply.	Section of Comprehensive Scheme.	5,759	1,600	1,600	C.C. grant increased from £1,450.	Scheme completed.
do.	Nenthead Water Supply	To utilise Hard Edge source and extend distribution.	12,750	3,500	3,500		Grant approved.
Border R.D.C.	Banks Water Mains Extension Scheme.	Branch (comprising 6,000 yds. 3in. pipe) of Scheme estimated to cost £15,750.	6,900	1,500	1,500		Grant approved.
do.	Roughton Gill Water Supply.	Extended additional supply.	80,000	10,000	10,000	Works delayed by bad weather.	Nearing completion.
Cockermouth R.D.C.	Augmented Water Supply Arrangements	Co-ordinated supplies between R.D.C. and Maryport U.D.C.	—	—	—	Negotiations in progress for formation of Joint Water Board.	
Ennerdale R.D.C.	Central and South Western Areas Water Supply Scheme.	Augmentation and replacement of existing unsatisfactory sources.	171,800	—	—	Part of Scheme costing £28,000 approved by Ministry.	Preliminary stages only.
do.	Ennerdale Lake Water Supply Scheme.		645,500	300,000	—	C.C. not concerned with this scheme (which is now complete) apart from distribution to Ennerdale R.D. by above scheme.	
Maryport U.D.C.		Augmented Supply to Maryport.	218,000	—	—	Preliminary negotiations with Ministry have taken place.	
Millom R.D.C.	Eskdale Water Supply		14,000	5,500	4,265		Scheme completed.
do.	Scheme for Northern Parishes.	Improvement of existing supplies.				Preliminary engineering inspection completed by Ministry.	
do.	Underhill Water Scheme.	Improvement of supply to Green Road and Underhill.	2,336	600	600		Grant approved.
do.	Silecroft Water Supply	Tank at Kirkbank.	2,989	1,600	694	C.C. grant increased from £550.	Scheme completed.
Wigton R.D.C.	Aspatria and Silloth	Intake works at Halls Beck, Reservoirs and Distribution mains.	85,875	—	—	Comprises Stage II. of R.D.C.'s Water Development Scheme.	Stage III. also in prospect but Ministry considering entire scheme stages II.—V.
do.	Blencogo Water Supply	New 4in. Main	1,880	—	—	No Ministry grant offered therefore C.C. have no liability for grant.	Approved by C.C.
Carlisle Corporation	River Eden Abstraction Scheme.	Abstraction of max. of 4 m.g.d. from River Eden to supplement supplies.	—	—	—	Scheme will enable Carlisle Corpn. to afford supply to Border R.D.C. from Geltsdale.	Scheme proceeding.

APPENDIX "B"

Wigton R.D.C.	Wigton Town Sewerage Scheme.	Extensive new works and replacement of existing sewer.	192,460	50,000	50,000		Grant approved—scheme proceeding.
do.	Oulton Sewerage Scheme.		10,750	—	—	Approved in principle by Ministry but not yet allowed to proceed.	Preliminary stages.

PULMONARY TUBERCULOSIS

AND

DISEASES OF THE CHEST

TUBERCULOSIS

As a preamble to the reports from the consultant chest physicians which follow, it will be useful to give certain figures for the whole county.

Notifications

The following table shows the notifications in Cumberland for 1954 and the preceding years:—

Year.	Pulmonary.	Non-Pulmonary.
1949	222	32
1950	231	48
1951	267	46
1952	259	45
1953	286	46
1954	262	57

Deaths

Deaths from pulmonary tuberculosis for 1954 amounted to 26 which is by far the lowest figure ever recorded. Deaths from non-pulmonary tuberculosis at 3 also represent a new low level.

The following table shows the deaths from pulmonary and non-pulmonary tuberculosis in Cumberland for 1954 and preceding years:—

Year	Pulmonary	Non-Pulmonary
1949	107	25
1950	101	15
1951	80	11
1952	43	9
1953	44	4
1954	26	3

Distribution

The distribution of deaths from pulmonary tuberculosis by areas has been received from the Registrar-General as follows:—

Urban Districts	Deaths	Death rate
Cockermouth	Nil	Nil
Keswick	1	.21
Maryport	2	.16
Penrith	Nil	Nil
Whitehaven	4	.16
Workington	5	.17
Aggregate of Urban Districts ...	12	.14

Rural Districts	Deaths	Death rate
Alston	Nil	Nil
Border	1	.03
Cockermouth	2	.10
Ennerdale	8	.27
Millom	1	.07
Penrith	Nil	Nil
Wigton	2	.09
Aggregate of Rural Districts ...	14	.11
Total for the administrative county	26	.12

It may be of interest to compare the deaths from pulmonary tuberculosis in East and West Cumberland for the past few years, and these figures are set out in the table which follows:—

Year	Total	East Cumberland Total	East Cumberland Percentage	West Cumberland Total	West Cumberland Percentage
1949 ...	107	36	33.6%	71	66.4%
1950 ...	101	22	21.8%	79	78.2%
1951 ...	80	18	22.5%	62	77.5%
1952 ...	43	7	16.3%	36	83.7%
1953 ...	44	7	15.9%	37	84.1%
1954 ...	26	4	15.4%	22	84.6%

The percentages given in the above table represent the percentage proportion of the total deaths occurring in the county during these years, allocated between East and West Cumberland. The actual figures of deaths, apart from the percentages have, of course, to be read in conjunction with the population figures of the two areas of the county which are as follows:—

East Cumberland ...	82,540
West Cumberland ...	134,060
	216,600

These population figures are the Registrar-General's estimated mid-1954 figures.

Expressed as a rate per 1,000 population, the deaths from pulmonary tuberculosis during 1954 worked out as follows:—

East Cumberland	...	.05
West Cumberland	...	.16

The detailed reports from the consultant chest physicians which follow, cover the position very fully, but one or two general comments may be of value. The first is that deaths from pulmonary tuberculosis in England and Wales fell during 1954 from 7,911 in 1953 to 7,069 for 1954, which represents a fall in deaths of some 11 per cent. Last year I expressed regret that our Cumberland figures had not shared in the fall. This year there is nothing to regret, because our Cumberland deaths from this condition have fallen from 44 to 26, representing a fall not of 11 per cent. but of 41 per cent.

As I said last year, there is, of course, another side to this welcome fall in the death-rate. From the point of view of the individual there is, of course, no doubt only one side, and that is that his expectation of life is prolonged, but from the community angle we must, as I have said more than once, not overlook the fact that an increasing number of cases are being *arrested* by anti-biotics and other lines of treatment but not *cured*. This means, as I see it, that an increasing number of persons will be mixing in the community as chronic infectious cases liable to become the focus of infection for new cases. It will, as I see it, take a generation to eliminate this complication.

With regard to the surgical treatment of pulmonary tuberculosis, one is very happy to say that the hopes we expressed twelve months ago for a reduction in the waiting list of cases for treatment by means of major surgery have been more than realised. The volume of work undertaken at the thoracic surgical centres for the region on the East Coast has been most gratifying, and it is perhaps worth recording that the Special Area Committee have transmitted their appreciation for this happy state of affairs to the Consultant Thoracic Surgeon chiefly concerned. Our waiting list for admission to hospital for major thoracic surgery is an item in the treatment of pulmonary tuberculosis which no longer gives cause for anxiety.

A report by the Deputy County Medical Officer on our Mantoux testing investigation carried out last autumn, and the reports of the consultant chest physicians follow.

REPORT OF A TUBERCULIN SURVEY AMONG INFANT SCHOOL CHILDREN IN THE ADMINISTRATIVE COUNTY OF CUMBERLAND

1954

W. H. P. Minto, M.D., D.P.H.,
Deputy County Medical Officer.

TUBERCULIN SURVEY OF INFANT SCHOOL CHILDREN

In the autumn of 1954 a tuberculin survey of infant school children was carried out in selected areas of the county. The aims of the survey were as follows:—

The first object was to determine the tuberculin sensitivity of a high proportion of the 5/6 year old children in the county.

Tuberculin sensitivity is widely regarded as an index of infection with tuberculosis in the community. It follows, therefore, that the survey should achieve its second aim which was to provide a reliable picture of the epidemiological pattern of tuberculosis in Cumberland. With this information it should be possible to concentrate the attack against tuberculosis in the areas where the disease is shown to be most prevalent, using in each those measures which seem likely to prove most suitable under local conditions. This is particularly important in a scattered rural county so that limited resources can be used to the best advantage.

The third object was to trace the source of the infection which had caused some of the children to show a positive reaction to the tuberculin test.

Indication of the prevalence of tuberculosis in Cumberland during the period in which the selected age group had been "at risk."

It is never easy to find a yardstick for the incidence of tuberculosis in a community and notification (morbidity) rates have been particularly suspect in this direction. On the other hand, one cannot deny the value of mass miniature radiography as a case finding procedure. In its first year of operation (1951) the unit examined 31,538 persons and detected 114 cases of active, newly discovered, tuberculosis. This, I think, constitutes a better epidemiological index than notification rates, and the figures for Cumbrian school children passed through mass miniature radiography in 1952 and 1953 are rather significant :—

Year		School Children Examined	Active T.B.	% of those examined	Inactive T.B.	% of those examined
1952	East Cumberland	3,069	1	.03	27	.9
	West Cumberland	1,573	1	.06	16	1.0
1953	East Cumberland	3,015	2	.07	19	.6
	West Cumberland	1,692	6	.35	21	1.2

It is, however, probably still true that the death-rates are the best guide to the incidence of tuberculosis in an area if they are considered over a period of time.

The mean pulmonary tuberculosis mortality, all ages, in Cumberland 1947-1953 was 0.4 per 1,000 population. The corresponding figure for all England and Wales for the same period was 0.33 per 1,000 population.

When the distribution of these deaths by district council areas is considered, it is found that among the thirteen districts which comprise the county there are only four whose mortality is above the mean, viz.:—

District	Mean Pul. T.B. Mortality 1947-1953	% above the County Mean 0.4
Ennerdale Rural District ...	0.69 ...	72.5%
Whitehaven Borough	0.56 ...	40 %
Workington Borough	0.51 ...	27.5%
Maryport Urban District ...	0.50 ...	25 %

The districts with the next highest mean mortality, but below the county mean are:—

District	Mean Pul. T.B. Mortality 1947-1955	% below the County Mean 0.4
Keswick Urban District ...	0.34 ...	15 %
Cockermouth Rural District ...	0.33 ...	17.5%
Penrith Urban District ...	0.28 ...	30 %

It is generally held that non-pulmonary tuberculosis is more frequently caused by the bovine bacillus, but it is probable that, where human tuberculosis is prevalent, the cases of meningitis (non-pulmonary) caused by the human bacillus are likely to more than balance those cases of pulmonary tuberculosis due to bovine organism. If this is substantially correct it can be assumed that the apparent fall in the incidence of non-pulmonary tuberculosis (stationary notifications and a falling death-rate) reflects the results of the milk production policy which will enable Cumberland to be declared an attested area this year (1955). Not only is there no evidence to show that the incidence of bovine tuberculosis in Cumberland is high, but the available facts indicate that the incidence is low.

All the available indices of the prevalence of tuberculosis lead to the conclusion that there is probably a higher incidence of pulmonary tuberculosis in West Cumberland than in East Cumberland, and that there is also a fairly wide variation in incidence through the county.

Planning of the Survey.

The Mantoux testing commenced in October, 1954, and was completed by the end of November. In order that this could be achieved, the areas selected were the main centres of population where the children were in larger schools or could attend central clinics to provide Mantoux testing sessions of a reasonable size.

Eleven areas were chosen, comprising the four largest towns in the administrative county, Workington, Whitehaven, Maryport and Penrith, a group of three smaller towns and adjacent villages, which form the main industrial community, the Cleator Moor/Frizington/Egremont area of the Ennerdale Rural District, and six small towns in different parts of the county, Keswick, Brampton, Longtown, Wigton, Aspatria and Silloth. The survey would in this way cover all those areas where the incidence of tuberculosis was suspected to be high and where the mean mortality rate (1947-1953) was known to be higher than the mean for the county as a whole and also, for purposes of comparison, a number of towns where no undue incidence of tuberculosis was to be expected from the facts available. It was decided to offer the test to every child who attended school in the selected areas and who was born between 1st September, 1947, and 1st September, 1949.

The balance of present-day scientific opinion suggests that an intradermal test is likely to be more satisfactory than any of the various jelly tests in that it is much less prone to give rise to doubtful results. It was decided to use in the Cumberland survey an intradermal Mantoux test of 0.1 ml. of a 1 in 1,000 dilution of standardised Old Tuberculin.

A joint letter was sent from the County Medical Officer and the Director of Education to the head teacher of each school explaining what was intended and asking for the co-operation of the teachers. When the lists of children were received an appropriate number of letters to parents were sent to each head teacher for distribution to the children.

It is of the utmost importance in a survey of this kind where case finding is one of the objects, that the co-operation and confidence of the family doctor should be obtained. Indeed one might go further and suggest that any survey that does not ensure this is doomed

to failure in its most important aspect which is to institute a "combined operation" against tuberculosis. Before the survey started the County Medical Officer explained to the local medical committee (of which he is a member) what was intended, thus ensuring that the general practitioners in the county were in the picture right from the start. When children were found to be Mantoux "positive" the first action taken was to send lists of these children to their family doctors. In the absence of any objections (and there were none) the child was referred to the appropriate chest physician, using a special form.

If a child was already under supervision at the chest centre as a contact or had had B.C.G. vaccination, and the probable source case was known, appropriate entries were made by the chest physician on the form mentioned above which was then returned to the health department forthwith. In all other cases the intention was that the chest physician should write to the parent and arrange for the "positive" reactor and all household contacts to attend at an appropriate chest session for investigation. If as a result a definite conclusion was reached, then the form, completed and suitably marked was returned as above. When the initial investigation was inconclusive the chest physician would return the form marked "this investigation continues" and a further "follow-up" form was sent to him.

The forms were designed so that there might be the fullest possible exchange of helpful information between the county health department and the chest physicians.

Results of the Survey (see Map, page 123)

The numerical findings of the survey are set out in the form of a table at the end of this section.

There were 4,279 children in the 5—6 year old group on the rolls of the schools in the selected areas. Parental consent to the test was obtained for 3,498 (82 per cent.) of these children. The consent rate is an important factor to be taken into consideration in a survey of this nature. A response of 82 per cent. compares favourably with that obtained in most recent surveys in this country where formal consent was obtained.

As the percentage of consents, with the exceptions of Longtown (72 per cent.) and Keswick (92 per cent.) all lie between 79 per cent. and 86 per cent. it seems justifiable to draw the following conclusions:—

(i) No single local factor appears to have influenced the consent rate.

(ii) The method of approach to the teachers and parents in Cumberland was a satisfactory one, as it achieved the object of obtaining consent.

(iii) The objection which has been made by some workers—that many parents withhold consent to a technique involving injection—cannot be sustained in this age group in this county.

Each school was visited on two occasions only, with an interval of 72 hours between each visit. At the first visit the Mantoux test was administered, and at the second, the reaction negative or positive was read. It was most unfortunate that the weather in October and November was unusually inclement and there were floods in many parts of the county. Furthermore, there were local epidemics, notably of mumps and infectious hepatitis. Consequently 495 children (12 per cent. of those on the rolls) missed or did not complete the test. Only 38 tests were not read, the remainder of the children (457) were absent on the day of testing.

The percentages of children on the rolls who completed the test in individual areas are shown at Col. (7) of the table, and it will be noted that, with the exception of Longtown (61 per cent.) they are remarkably constant, both between East and West Cumberland and the individual areas. It can be deduced that the numbers who completed tests in each area are sufficient to provide a representative sample suitable for comparison.

The total number of positive reactors was 294 (9.8 per cent.). Of these 237 (10.8 per cent.) were in West Cumberland and 57 (7.1 per cent.) in East Cumberland. There was a very wide variation in the incidence of positive reactors in the individual areas varying from 3.5 per cent. in the Silloth area to 16.7 per cent. in the Frizington/Cleator Moor/Egremont area.

In East Cumberland 73 per cent. of the children on the rolls completed tests and 7.1 per cent. were found to be positive reactors, while in West Cumberland of the 69 per cent. who completed tests, 10.8 per cent. were positive. It is true to say, therefore, that the incidence of tuberculous infection in the age group tested, as indicated by the tuberculin reaction, shows a similar relationship between East and West Cumberland as that evidenced by the mortality rates and mass radiography surveys in 1952 and 1953, and is generally in accordance with what is known of the natural history of tuberculosis in Cumberland.

East Cumberland.

Turning now to consider the results in East Cumberland in more detail it is found that the incidence of positive reactors is extremely low, in comparison with other recent surveys in other parts of the country, for what is a predominantly rural agricultural area. Cumberland has been in the past a stock-raising county, with the result that virtually no milking cows are imported into the county. This, combined with the energetic policy which has led to the declaration of an attested area, must be an important factor in the low incidence of bovine tuberculosis over the last eight years or so which these findings confirm.

The figures of positive reactors in *Silloth*, *Aspatria* and *Wigton* are unusually low, and although no definite conclusion can be drawn at present, this might merit further investigation in a more comprehensive local survey later.

It is of interest that in *Longtown* where the relatively low consent rate had been attributed to a high proportion of refusals from the mid-European workers' camp nearby, four of the five positive reactors were children of Polish descent. This would indicate that special measures should be taken with regard to the investigation of this community in the future.

Penrith is of some importance, as not only has it the largest population, but on the findings of the survey may be taken to be a town typical of East Cumberland (7.7 per cent. positive reactors) and should be useful for comparison later with the typical West Cumberland town of Maryport.

Following upon the survey at *Brampton* (10.5 per cent.) where a new active case of non-pulmonary tuberculosis was found, three cases of open tuberculosis in cattle were discovered, one involving tuberculosis of the udder. It follows that bovine infection may well have been a relevant local factor here.

Keswick showed a higher incidence (12.2 per cent.) than was to be expected relative to the other areas. In fact, this town showed the second highest result in the county. It should be noted, however, that, although below the mean mortality rate for the county, Keswick did come next to the industrial areas in West Cumberland and was just above the average for England and Wales. The problem has not been solved and will require further local investigation.

West Cumberland.

In West Cumberland the highest incidence was found in what has always been regarded as the "black spot" for tuberculosis—Ennerdale Rural District (Frizington/Cleator Moor/Egremont area). 16.7 per cent. of the children tested were found to be positive reactors. It has been known for many years that the Ennerdale Rural District has a much higher death-rate from pulmonary tuberculosis than any other part of the county.

The *Whitehaven* incidence of 11.6 per cent. is in accordance with what was previously known of the incidence of tuberculosis in the area. A striking feature here which should be elucidated is that there is a large modern infant school on each of the two housing estates. The schools are of similar size and the one on the new estate which is still in the process of completion yields 9 per cent. positive reactors, while the percentage positive on the older estate is 24 per cent. Here are two largely closed communities in one town where careful case finding and a subsequent full investigation in which the district Medical Officer of Health would have an important role, may provide an answer to the method of spread of the disease.

Maryport (incidence 10.8 per cent.) can be regarded in this respect as typical of a West Cumberland town for purposes of comparison.

It is rather surprising in the light of mortality rates to find *Workington* with an incidence (6.1 per cent.) just over half that of her twin borough Whitehaven. The relatively small number of Workington children found "positive" in the survey gives one reason to hope that the apparently low incidence of infection may be a real one and that conditions here are yielding to the measures of tuberculosis control which have been introduced in recent years. The results of the Mantoux testing prior to B.C.G. vaccination in the 13 year old group here should be most enlightening in confirming this suggestion, or otherwise.

Results of the case finding procedure.

At the time of writing, three months after the end of the survey, forms have been returned by the chest physician in respect of the 57 positive reactors in East Cumberland, that is to say the children themselves and some of their immediate household contacts have been dealt with at the chest clinic. In the West, however, only a small proportion of the 237 investigations can be regarded as complete. So far, little can be deduced about the value of the actual case finding procedure. It should be remembered that it is in the later stages of the case finding procedure that new cases are most likely to found, and this is particularly true of the Whitehaven and Ennerdale Rural District Areas, where the positive reactors have not yet been fully investigated.

In *East Cumberland,* only 3 of the 57 positive reactors failed to keep the chest clinic appointment. None of the positive reactors had been given B.C.G. vaccination prior to the survey.

Eighteen children showed radiological evidence of an inactive primary complex, and in 36 no radiological abnormality was detected. Of the latter, three were diagnosed as cases of non-pulmonary tuberculosis.

Of the positive reactors 15 were found to be reasonably close contacts of known cases of tuberculosis. Of these known cases, 12 were cases of tuberculosis previously notified in Cumberland, and 3 were notified cases resident outside the county. In 3 of the 12 notified cases in Cumberland it was not realised prior to the survey that the positive reactor child was indeed a contact. Two of these previously unidenti-

fied source cases were a maternal uncle and aunt respectively who had lived with the child's family for a fairly long period, but whose notifications showed a different address from that of the child. The third was a daily help in the positive reactor's home.

Two parents were found to have calcified tuberculous lesions (inactive) and one child's mother, who is employed in the school meals service, had three small tuberculous foci at the left apex and is now under observation at the chest clinic.

The search for a probable source case continues in 13 cases.

As far as *West Cumberland* is concerned, at the time of writing, forms are now available for *Maryport.*

Here 400 children (74 per cent. of those on the rolls) were tested and 43 (10.8 per cent.) were found to be positive.

Of the positive reactors, 4 did not attend the chest clinic. Six positive reactors had been given B.C.G. vaccination prior to the survey as contacts of known cases of tuberculosis.

In Maryport, 23 children showed radiological evidence of a primary complex (presumed quiescent) and in addition, 4 cases of active primary pulmonary tuberculosis were diagnosed (one of these had been referred by the family doctor, his attention having been drawn to the child's condition by the letter from the County Medical Officer informing him of the positive Mantoux test).

Six children (not including those who had had B.C.G. vaccination) showed no radiological abnormality —they remain under observation at the chest clinic.

In all, 23 of the positive reactors (including those six who had had B.C.G.) were found to be reasonably close contacts of cases of pulmonary tuberculosis. Of these, 15 were Cumberland notified cases and the children had been seen as contacts prior to the survey. The remaining 8 were contacts of known cases, but for one reason or another the relationship was not sufficiently obvious to have been discovered before the survey. It is of interest to analyse the reasons why these eight contacts had been "missed."

1. The known case is a cousin, of different name, who is from time to time resident in the positive reactor's home.
2. The child's mother and aunt are stated to suffer from pulmonary tuberculosis. They are not known cases and as a result of domestic trouble, are no longer resident in the county.
3. The child's aunt, different name and address, is a notified case. She has often looked after the child at her own home.
4. A sputum positive neighbour (notified case) has frequently taken care of this child and the siblings.
5. A known case, different name and address, is a distant relative and frequent contact.
6. Maternal uncle (now deceased), different name and address was a known case and close contact.
7. Cousin, notified case, different name and address, has often taken care of this child.
8. Child stays with a sputum positive neighbour (notified case) when parents are away from home.

The search for a probable source case continues in respect of 16 of the Maryport positive reactors.

The survey has been successful in its primary objective of determining the prevalence of tuberculous infection in the county, but it may be that too much has been attempted with limited resources for the case finding method which has been employed to be fully efficient. It seems desirable that future surveys with case finding as a primary objective should be concentrated in smaller areas where all the forces available may be brought into action over a shorter period of time. Tuberculin surveys have been found to be a useful means of case finding elsewhere, especially when applied to the school entrant group. The case finding aspect of this survey has not yet progressed far enough for one to reach a definite conclusion as to whether or not this observation applies to Cumberland or even to certain parts of Cumberland. This question can be answered only when the case finding is complete.

To sum up, all that can be definitely stated at this stage in regard to the case finding method is that its operation takes much longer than had been anticipated, but that several unsuspected benefits other than actual case finding accrue. For instance, a number of probable source cases have been detected with different names and addresses from those of the positive child reactors (maternal aunts and uncles, lodgers, neighbours, etc.), thus enabling other young children, negative reactors at risk, to be offered B.C.G. vaccination—a practical demonstration of the need of increased efforts in tuberculosis health education, at chest clinics and elsewhere.

The main object of the survey was to determine as accurately as possible the prevalence of tuberculous infection in selected areas of the county as indicated by the tuberculin conversion rate in young school children. This far, I think, the survey has been successful and it has shown a wide and sometimes unexpected variation in different areas.

The survey in relation to B.C.G. vaccination and as a guide to future policy.

At present, B.C.G. vaccination is being offered to every 13 year old school child in Cumberland who is found to be a negative reactor to a 1 in 1,000 Mantoux test. This scheme will provide in the very near future similar information to that obtained in the present survey, but relative to the 13 year old group in the selected areas and also in all other parts of Cumberland. It will then be possible to make a further assessment of the prevalence of tuberculous infection as indicated by tuberculin conversion of this age group in the county. As an example, the figures for pre B.C.G. Mantoux testing of the 13 year old group are available for Maryport and Penrith:

Area	No. Mantoux Tested	No. Positive	% Positive 13-year old	% Positive 5-6 year Survey
Maryport ...	106 ...	37 ...	34.9 ...	10.8
Penrith ...	123 ...	29 ...	25.6 ...	7.7

It will be noted that the relationship of percentages positive in the two age groups are almost identical for Maryport and Penrith. In each town, for every positive reactor in the 5-6 year group there are three

positive reactors at 13 years of age. In other words, in both Maryport and Penrith a child aged 13 years is three times more likely to have contracted a tuberculous infection than a six year old, but the chance of infection at either age is greater in Maryport.

By the end of 1955, the following three questions will have been answered:—

1. What is the extent and distribution of tuberculisation of the 5-6 year old group in the selected areas?
2. What is the value of a tuberculin survey of the school entrant group as a means of case finding?
3. What is the extent and distribution of tuberculisation of the 13 year old group in the county?

It should then be possible to decide the policy which is likely to employ the available resources to the best advantage in an attempt to bring nearer the day when tuberculosis will become an unimportant disease in Cumberland.

It is safe to say that before long no Cumbrian baby is likely to be infected with bovine tuberculosis within the county as he grows up. We will then be concerned largely with his protection from human tuberculosis.

There can be no doubt that poverty and tuberculosis are close and ugly allies, but it is just as certain that, before infection with tuberculosis of the human type can occur, there must have been contact with a person who has open disease in the lungs. That and that alone is the primary and fundamental factor concerned in the spread of tuberculosis. Such factors as poverty, poor housing, malnutrition, racial susceptibility and climatic conditions may be important, but they are secondary factors.

The obvious methods of approach to this problem are the detection and treatment of these "open" cases and the protection of susceptible contacts, using the term "contact" in its widest sense.

Different areas may well require different treatment if the best results are to be obtained. Speaking very generally, the population of *Ennerdale Rural District* for instance is said to have been in the past somewhat hesitant to submit itself to investigation with regard to tuberculosis. It may be that many have experienced in their families the sorrow and horror of the terminal stages of phthisis in the past and the impression left dies hard. Health education regarding tuberculosis will be an uphill task here, and compulsion as used in the Scandinavian countries is contrary to the British way of life. The survey shows that at least 16.7 per cent. of the school children have or have had a tuberculous infection before reaching the age of 7. If the figures for Maryport and Penrith are a good index it will transpire that some 50 per cent., probably more, of the 13 year old Ennerdale children will be positive reactors. If this is so, it may be desirable to seek approval to offer B.C.G. vaccination to all tuberculin negative school entrants (5 year olds) as a " pilot " scheme and to simultaneously offer mass radiography examination to the contacts of the positive reactors. Mantoux tests and B.C.G. would still be offered to 13 year old children to ensure their tuberculin conversion before they leave school and enter industry. When those who had had B.C.G. at five reached thirteen, they would be offered another Mantoux test and those who had reverted would be offered revaccination.

In *Workington* on the other hand simpler and more orthodox measures would be as likely to produce the desired effect. The other areas should be considered each on its merits.

It cannot be too strongly emphasised that the methods of tuberculosis control should not be too rigidly laid down at any level, they must be adapted to suit local conditions within a county or, possibly a town, and it should be added that these local conditions must be kept constantly under watchful review so that the methods can be changed to meet altered circumstances.

RESULTS OF THE SURVEY

(1) Serial No.	(2) Area.	(3) No. of children in age group on rolls.	(4) No. of consents.	(5) % of consents.	(6) No. of completed tests.	(7) % of children on rolls (3) who completed tests.	(8) No. Positive.	(9) % Positive of those shown at Col. (6).
1.	Workington	998	792	79	686	69	42	6.1
2.	Whitehaven	985	788	80	665	68	77	11.6
3.	Maryport	544	466	86	400	74	43	10.8
4.	Frizington/Cleator Moor/ Egremont	650	559	86	450	69	75	16.7
Total all areas West Cumberland		3,177	2,605	82	2,201	69	237	10.8
5.	Silloth	123	98	79	87	71	3	3.5
6.	Aspatria	111	95	86	86	77	4	4.7
7.	Wigton	155	123	80	117	75	6	5.1
8.	Longtown	136	98	72	83	61	5	6.0
9.	Penrith	375	303	81	274	73	21	7.7
10.	Brampton	83	67	81	57	69	6	10.5
11.	Keswick	119	109	92	98	82	12	12.2
Total all areas East Cumberland		1,102	893	81	802	73	57	7.1
TOTALS		4,279	3,498	82	3,003	70	294	9.8


N
W
E
S
BORDER R.D.C
Longtown
6.0 %
Brampton
10.6 %
CARLISLE (County Borough)
Silloth
3.5 %
SOLWAY FIRTH
WIGTON R.D.C
Wigton
5.1 %
Aspatria
4.7 %
PENRITH R.D.C
Alston
ALSTON with GARRIGILL R.D.C
Maryport (Urban District)
10.6 %
Cockermouth (Urban District)
Workington Municipal Borough
6.1 %
COCKERMOUTH R.D.C
Keswick (Urban District)
12.2 %
Penrith (Urban District)
7.7 %
11.6 %
Whitehaven Municipal Borough
ENNERDALE R.D.C
16.7 %
Seascale
MILLOM R.D.C
Millom
ADMINISTRATIVE COUNTY OF CUMBERLAND
Mean Tuberculosis Mortality 1947 - 1953.
Whole County 0·6 Per Thousand
Mean or lower mortality.
Mortality up to 30% above mean
Mortality from 31-60% above mean
Mortality over 60% above mean
Carlisle County Borough
District Council Boundaries
'West Cumberland'/'East Cumberland' Boundary
Figures in Circles are percentages of positive reactors found in the survey

EAST CUMBERLAND

(Dr. W. Hugh Morton, Consultant Chest Physician)

Introduction.

This report for 1954 records a considerable measure of progress in our campaign against tuberculosis. Not only has there been a most decided decline in the total number of new cases found to have extensive disease, but the number of cases found to be infectious at the end of the year has also declined.

The waiting lists have reached a new low level and, indeed, at the time of writing this report (May, 1955) these are practically at zero.

Such results must not cause complacency; whilst it is highly satisfactory to feel that the number of infectious cases in this community shows a steady decline it must not be forgotten that the absence of infection means a larger number of susceptible persons who are not only non-infected but are completely unprotected.

Pulmonary diseases other than tuberculosis account for the vast majority of cases seen and investigated at the chest centre, and a short section on these is appended as in previous years.

Tuberculosis.

Notifications.

In the East Cumberland area in 1954, notifications for the pulmonary type of the disease rose from 140 to 170 and the notifications of non-pulmonary disease dropped from 43 to 34. The increased number of pulmonary notifications undoubtedly reflects not only the high standard of co-operation which exists between the general practitioners and the chest centre but also the increased effort made during the year to discover new cases. Most of the increase in the notifications came from the Carlisle City area, the County area only being responsible for an additional three cases.

The notification of new cases of pulmonary tuberculosis is only made when we are satisfied that there is indeed some degree of *active* disease. Many patients, when first seen, present undoubted radiological evidence of old disease and clinical signs confirming this, but, if we are satisfied that the disease is well healed, such cases are not notified although they remain under chest centre supervision for months or even years. I feel that the supervision of such cases is most important as anything likely to lower the patient's general resistance such as an inter-current non-tuberculous

inflammatory episode may easily result in re-activation of the old tuberculous disease, and if such patients are under observation appropriate treatment for the tuberculosis can be instituted almost immediately. Only then would such a case be notified.

Although notification of a patient as suffering from tuberculosis does not carry the same stigma as it did 15 or 20 years ago, some lesser degree still remains. The conscientious patient taking out an insurance policy to cover house purchase may find that the compulsory disclosure of his having been notified as a case of tuberculosis in the past results in his proposal for insurance being turned down by the insurance company with relative domestic hardship. Notification therefore remains a serious matter for the patient and should only be carried out when one is satisfied beyond reasonable doubt that *active* disease is present.

The assessment of cases of pulmonary tuberculosis as active is, however, becoming a most difficult problem. As noted later in this report we are becoming increasingly familiar with the patient who, after adequate chemotherapy, presents evidence of cavitation but negative bacteriological findings, and the same problem has arisen in new cases who have had no previous treatment for tuberculosis. Increasing emphasis is therefore being placed on exhaustive radiological investigations and particularly tomography and bronchography in the investigation of apparently in-active cases.

On the other hand, I must stress the importance of notifying cases of active non-pulmonary tuberculosis when these are first seen. Many such cases have undoubtedly not been notified in the past, and, as the vast majority of cases of tuberculosis in this area—both pulmonary and non-pulmonary—are of human origin, this failure to notify active non-pulmonary disease allows a potential pulmonary case to remain undiagnosed and so continue to spread infection. A few instances occurred during the past year; in one case a new case of pulmonary tuberculosis was seen for the first time and close enquiry into the family history elicitated the fact that a child of this patient had had tuberculous glands removed three years previously and had not been notified.

The mass radiography unit allotted to the Special Area continues to play a vital role in the discovery of new cases and has been responsible for the finding of no less than 36 of the new cases of pulmonary tuberculosis in the whole of the area covered by the East Cumberland Hospital Management Committee.

Table 1 gives the number of notifications throughout England and Wales for the years 1948 to 1954:—

Table 1.

Notifications in England and Wales

Year.	No. of Notifications.
1948	62,600
1949	63,300
1950	59,000
1951	49,440
1952	41,904
1953	40,917
1954	36,973

Table 2 shows the notification in East Cumberland for 1952 and 1953 and 1954, and for the whole of the county for the preceding four years: —

Table 2.

Year.	Pulmonary.	Non-Pulmonary.
1948	195	... 45
1949	222	... 32
1950	321	... 48
1951	267	... 46
1952	79	... 20
1953	63	... 18
1954	66	... 19

The sex and age distribution of new cases seen during 1954 are set out in Table 3 and apply to the county area only, the figures in parenthesis being the number of cases from the whole of the East Cumberland Hospital Management Committee area, including the County, City of Carlisle and North Westmorland. I have added these figures in parenthesis as the larger figures undoubtedly give a truer picture of the sex and age distribution of the disease as it affects the population in the East Cumberland area. I would particularly draw attention to a new feature of this table for 1954—i.e., the marked increase in the number of new cases falling in the 5 to 15 age group, particularly in the county area. Whilst in 1953 no new cases of tubercle in this group were found in the county area, there have been no less than eight cases diagnosed as suffering from tuberculosis in 1954, a most disturbing factor in these days of a welfare state.

Table 3.

	Under 5	5-15	15-25	25-35	35-45	45-55	55-65	65 plus
RESPIRATORY								
Males	—(2)	5(7)	4(14)	4(12)	6(10)	1(11)	7(12)	5(7)
Females	—(1)	3(7)	10(26)	9(32)	7(13)	3(12)	2(2)	—(2)
NON-RESPIRATORY								
Males	—(—)	4(4)	1 (3)	1 (3)	—(—)	— (2)	—(—)	—(—)
Females	1 (2)	6(7)	3 (6)	— (3)	1 (1)	— (2)	1 (2)	1 (1)

Otherwise, the figures in this table show that as far as the county area is concerned there has been no obvious alteration in the age or sex distribution of the new cases as compared to 1953. The number of cases where tubercle bacilli have been isolated has remained practically stationary. What is striking, however, is the large proportion of new cases who present definite evidence of tuberculous cavitation when first seen (see Table 4a); this number being approximately half of the total number of new notified cases.

Although I still feel that the finding of tubercle bacilli in a patient's sputum is most important not only in diagnosis but also in treatment and prognosis, there is no doubt but that we find an increasing number of new patients with definite radiological evidence of tuberculous cavitation but whose sputum does not contain tubercle bacilli. The examination of sputum is interpreted in its widest sense as including laryngeal swab and gastric lavage examinations. Such findings strongly suggest that the present classification of cases of pulmonary tuberculosis into R.A. (negative cases) and R.B. (positive cases) is completely out of date and that the only valid distinction to be made should be between those with cavitation and those without cavitation, the examination being based on the results of tomography and bronchography. I feel this distinction is particularly important in that it explains to a large extent our increasing and steady demands on the thoracic unit.

This distinction between those with cavitation and those without cavitation has undoubtedly been appreciated by the Ministry as it is embodied in the recent new classification of tuberculosis for mass radiography purposes.

Similar findings are increasingly found in patients who have already had chemotherapy: a cavity still persists radiologically although tubercle bacilli are no longer found on examination. Here the negative bacteriological findings are easily understood, and, together with the great improvement in the patient's clinical condition, a normal sedimentation rate and the absence of toxaemia, might lull one into accepting the disease as quiescent. Tomography would, however, reveal cavities in many such cases, and these cavities require in turn to be differentiated into those which are undoubtedly tuberculous and a potential danger to the individual concerned, and those which are the end result of successful chemotherapy and are no more than a simple cyst.

It will be appreciated therefore that the observation and investigation of apparently healed cases of tuberculosis takes considerable time and may last for many months before a definite diagnosis of active disease is made.

Table 4 (a) gives the pulmonary notifications for 1954 and these are further classified as to whether they are infectious or non-infectious and also the extent of the disease which they have on first examination. The figures given apply to the county area whilst the figures in parenthesis again refer to the whole of the East Cumberland area.

Table 4(a).

RESPIRATORY	R.A. 1	R.A. 2	R.A. 3	R.B. 1	R.B. 2	R.B. 3
Males ...	9(21)	9(20)	4(4)	2(5)	3(9)	5(16)
Females	10(39)	11(24)	3(6)	1(3)	2(10)	7(13)
No. of above respiratory cases referred by M.M.R.						
Males ...	4(10)	2 (4)	—(—)	1(1)	1 (2)	—(—)
Females	—(9)	— (5)	1 (1)	—(2)	1 (2)	—(—)

Table 4 (b) shows the new cases further classified into those with cavitation on initial examination and those without cavitation.

Table 4(b).

	With Cavitation	Without Cavitation	Total	Percentage with Cavitation
Carlisle City	43	55	98	43.88%
East Cumberland ...	32	34	66	48.48%
North Westmorland ...	2	4	6	33.33%
Total	77	93	170	45.29%

Deaths

There are still unfortunately a small number of patients on our registers who have had extensive and active disease for many years and for whom sanatorium treatment has done little. Even in spite of the undoubted improvement which has resulted in these cases it is surprising, considering their gross respiratory crippling, how they have managed to survive for such comparatively long periods.

Tables 5 and 6 show respectively the number of deaths from tuberculosis in England and Wales, and for the Eastern Division of the County for 1954 and prior to 1953 for the whole of the County area.

Table 5.

Deaths in England and Wales

Year.	No. of Deaths.
1949	23,320
1950	18,750
1951	12,031
1952	9,335
1953	7,911
1954	7,069

Table 6.

Deaths in the county area for 1949-1952, and for the Eastern Division of the county for 1953 and 1954.

Year	No. of Deaths Pulmonary	Non-Pulmonary
1949	107 ...	25
1950	101 ...	15
1951	80 ...	11
1952	43 ...	9
1953	7 ...	1
1954	4 ...	—

The number of deaths has dropped to a new low level during 1954, and in the Eastern Division of the county total 4.

Chest Centre Statistics

Table 7 gives the number of notified cases of tuberculosis, both pulmonary and non-pulmonary, on the East Cumberland Register for 1954. The figures

in parenthesis in the grand total relate to the corresponding figures for 1953.

Once again it is pleasing to report a decline in the number of cases who at the end of the year were still infectious—a fall of 12 from 68 to 56.

Contact Examinations

All contacts known to us are examined radiologically, and all children and an increasingly large number of adolescents and adults have been Mantoux tested. We continue to vaccinate with B.C.G. all negative re-actors after a double Mantoux test, not only contacts but members of hospital staffs in the East Cumberland area.

Although much work has been done in this direction, there is, I am afraid, a very large loop-hole still remaining and one for which I can offer no ready solution. When a new patient suffering from the disease is first seen it is a comparatively easy matter to get his immediate family contacts along for examination. This often includes brothers and sisters who are themselves married and live in different parts of the county or city as the case may be, but in many cases the patient takes our instructions literally to mean his own immediate family, and although in his mind this may include those who have married, one finds that a married sister is not likely to be included in the list of contacts supplied, presumably because she has changed her name.

There is no doubt but that the tuberculisation state of the population is rapidly changing and that re-orientation of thought and outlook is necessary. Many tuberculin surveys have been recently carried out, e.g., in Ireland, Mid-Wales and in two London Boroughs, as well as to a limited extent in the county area, the survey here being confined to school children of the 5, 6, and 7, and 13-14 age groups. The striking fact about all these surveys is the startlingly low number of children and adolescents found to have a positive Mantoux test. Under 10 years of age the number of children in these surveys found to be Mantoux positive has varied between 5 per cent. and 10 per cent., whilst in adolescents between the ages of 15 and 25 only 25 per cent. to 30 per cent. are Mantoux positive.

Table 7.

CLINIC REGISTER AS AT THE END OF 1953—COUNTY OF CUMBERLAND—EASTERN DIVISION.

	Respiratory.			Non-Respiratory.			Totals.			Grand Total
	M.	W.	Ch.	M.	W.	Ch.	M.	W.	Ch.	
Cases on Clinic Register on 1st January, 1954 ...	203	180	10	17	26	20	220	206	30	456 (393)
Additions to Register during 1954	32	45	13	2	7	14	34	52	27	113 (101)
	235	225	23	19	33	34	254	258	57	569 (494)
Removals from Register during 1954	18	15	6	3	1	6	21	16	12	49 (38)
Number of cases on Register on 31st December, 1954	217	211	16	17	33	26	234	244	42	520 (456)
Number known to have had a positive sputum within the preceding 6 months	31	24	1	—	—	—	31	24	1	56 (68)

STATEMENT OF ATTENDANCES AT CHEST CENTRE, CARLISLE, DURING 1954

	East Cumberland		Carlisle City		North Westmorland		Total			Total figures for 1953
	R.	N.R.	R.	N.R.	R.	N.R.	R.	N.R.		
1—No. of NEW CASES seen:—										
Adult Male	334	3 ...	357	2 ...	37	1 ...	728	6	)	
„ Female	199	5 ...	610	5 ...	41	1 ...	850	11	)	
Male child	84	1 ...	96	1 ...	9	— ...	189	2	)	
Female child	56	5 ...	70	— ...	9	1 ...	135	6	)	1927	1487
2—No. of OLD CASES seen:—										
Adult Male	716	19 ...	891	22 ...	117	11 ...	1724	52	)	
„ Female	738	48 ...	1140	50 ...	93	24 ...	1971	122	)	
Male child	156	11 ...	297	18 ...	36	3 ...	489	32	)	
Female child	138	18 ...	183	22 ...	11	8 ...	332	48	)	4770	4017
3—No. of NEW CONTACTS seen:—										
Adult Male	172	— ...	258	— ...	8	— ...	438	—	)	
„ Female	239	— ...	364	— ...	16	— ...	619	—	)	
Male child	195	— ...	246	— ...	25	— ...	466	—	)	
Female child	155	— ...	309	— ...	23	— ...	487	—	)	2010	1722
4—No. of OLD CONTACTS seen:—										
Adult Male	36	— ...	89	— ...	—	— ...	125	—	)	
„ Female	66	— ...	155	— ...	2	— ...	[illegible]	—	)	
Male child	248	— ...	412	— ...	27	— ...	687	—	)	
Female child	153	— ...	419	— ...	31	— ...	603	—	)	1638	992
5—No of cases seen by physiotherapist:—										
Adult Male	47	— ...	88	— ...	5	— ...	140	—	)	
„ Female	96	— ...	123	— ...	6	— ...	225	—	)	
Male child	94	— ...	261	— ...	27	— ...	382	—	)	
Female child	118	— ...	130	— ...	1	— ...	249	—	)	996	1056
6—No. of cases of Pneumoconiosis							45*		...		44
7—No. of A.P. refills given	1092	...	1543	...	56	...	2691		...	2691	3019
8—No. of P.P. refills given	1618	...	3209	...	142	...	4969		...	4969	4607
9—No. of E.P. refills given	150	...	246	...	31	...	427		...	427	129
10—Screen examinations only ...	221	...	229	...	5	...	455		...	455	349
11—Aspirations	37	...	41	...	21	...	99		...	99	132
12—Domiciliary visits										366	341
TOTAL ATTENDANCES ...										20348	17895

* This figure is already included in No. 1 (adult males).

There is no doubt that this latter age group is an important one in tuberculosis. Young adolescents are far more likely to develop progressive disease at this age, and whilst it is true that the primary infection in school children usually runs a benign course it is a mistake to assume that progressive disease only occurs when they leave school. I have already quoted the figure of eight new county school children as having been found to be suffering from active disease during 1954.

As suggested earlier in this report the number of new notifications and the number of deaths in the area do not give sufficient indication of the progress made in our anti-tuberculosis measures. The changing rate of the incidence of the primary infection in our community does, however, give some indication. As present positive re-actors in the 5 to 7 age groups have, in co-operation with the School Medical Department, been carefully investigated along with their families, and whilst no new cases of active tuberculosis have been discovered as a result of these investigations, the time is rapidly aproaching when positive Mantoux re-actors in school children of 5 to 7 will undoubtedly have much more significance than they even have today. Some writers have even suggested that such children will in future be notified and point to the practice in Norway where only 7 per cent. of the school leavers were found to be Mantoux positive in Oslo in 1953.

The extension of B.C.G. vaccination to negative re-actors in the 13 to 14 age groups of school children by the local authority medical staff is warmly welcomed. This measure alone should undoubtedly result in a very considerable decline in the number of new cases of pulmonary tuberculosis amongst adolescents who have just entered industry. I feel, however, that the present rate of progress so far as B.C.G. vaccination goes is much too slow.There is still no protection available for the children below the age of 13 years and none for infants, who are prone to develop the acute miliary type of the disease, unless they are contacts.

The conversion rate after B.C.G. vaccination remains high; during the year we had no case who failed to convert. I consider the post-B.C.G. Mantoux test most important. Whilst one can assume that prac-

tically 100 per cent. of our B.C.G. vaccinations will result in conversion for a Mantoux negative state to a Mantoux positive state there is always the possibility that through faulty vaccination conversion may not take place, and, should the child develop an active tuberculous lesion later, omission to do a post-B.C.G. Mantoux test would not only have serious repercussions on the B.C.G. scheme, but would result in considerable difficulty in diagnosis and assessment.

In contacts so vaccinated, frequent attendances for examination at the chest centre are no longer required or desirable and yearly examinations of such children are at present carried out. It is intended also during the coming year to retest, if possible, all children who were converted five years ago when we first started. It is, however, a very different matter with those children who are Mantoux positive when first seen. The younger the child is who is Mantoux positive the closer should be his supervision during the first year or two, and it is our practice to examine such children at six monthly intervals at least. Children also require closer radiological supervision towards puberty and immediately afterwards.

Institutional Treatment

Table 10 gives the number of beds available for the treatment of tuberculosis in the area covered by the East Cumberland Hospital Management Committee.

Table 10.

Institution.	No. of beds.
Meathop	12
Blencathra	48 (temporary allocation)
City General Hospital ...	15
Longtown Hospital	23 ...
Cumberland Infirmary ...	10
Ormside Sanatorium ...	20
Ward 7, City General Hospital	2
Ward 8, City General Hospital	2

Table 11 gives the number of cases from the Eastern Division of the county admitted to institutions for treatment during 1954:—

Table 11.

Institution.	Adults	Children
Blencathra	33 ...	—
Meathop	4 ...	—
Longtown	47 ...	—
City General Hospital	24 ...	9
Cumberland Infirmary	17 ...	—
Ormside	26 ...	2

We continue to advise complete bed rest with chemotherapy for all patients. Much has been written recently about the good results of ambulant chemotherapy with the patient even at work. Personally, I feel that any value in this type of treatment must be confined to cases where a diagnosis of *active* disease is very doubtful, or where the case is a chronic one who has had a recent minimal exacerbation. In such cases I can well appreciate the good psychological result in allowing a patient to continue at work and yet feel that he is being treated. I very definitely feel, however, that a patient who has active disease and who is ill enough to require chemotherapy is also ill enough to be on complete bed rest.

Treatment by chemotherapy is now firmly established and consists of the administration of streptomycin along with one or other of the other antibiotics; we prefer isoniazide. In the vast majority of cases no ill effects result from this treatment, but occasionally a patient has been found to be unduly sensitive to one or other of the anti-biotics, thus necessitating the substitution of another anti-biotic, or even in a few cases desensitising against the offending anti-biotic. In suitable cases minor collapse measures such as artificial pneumothorax and pneumoperitoneum are carried out, and we are now in a position to assess the results in cases who underwent collapse therapy in 1951 and 1952. In most of these the collapse therapy has been terminated during the past nine months and in every case the final result has been a good one. Many of the cases in whom a pneumoperitoneum was induced during these two years have improved so much that major surgery has been possible and has now been carried out, again with good results.

Since 1950 at least, all patients with pleural effusion and pleurisy considered to be tuberculous have been treated on orthodox lines with chemotherapy, and although a sufficient length of time has not elapsed

to judge of our results, it is worth while noting that no such case has developed further tuberculous disease to date. Tuberculous pleurisy may seem to the patient to be a mild and short lived illness, but the pleurisy is undoubtedly a gross manifestation of a minor pulmonary lesion, and whilst these latter lesions may not be demonstratable on the radiograph or tomograph, statistics have in the past shown that, of such patients who are not adequately treated, some 30 per cent. return later during the five years following the pleurisy with further pulmonary disease. Some statisticians have even given the figure of 25 per cent. returning with gross pathology in a period of two years. Chemotherapy given in these cases has averaged three months and paracentesis has been carried out in all cases of effusion for diagnostic purposes and to relieve pressure symptoms. We do not advocate breathing exercises and no degree of respiratory disability has resulted.

The incidence of pulmonary tuberculosis with diabetes in this area merits special mention. During the past year we have treated eight patients suffering from both pulmonary tuberculosis and diabetes; of these four were newly notified during the year. It is estimated that throughout England and Wales there are three diabetics per 1,000 of the population and that of the diabetics about 3 per cent. show radiological and clinical evidence of tuberculosis, facts which make it imperative that all diabetics should have regular periodic chest x-ray examinations. Treatment of both diseases is of necessity to be carried out in hospital or sanatorium, and we have looked upon these cases as emergencies in every sense of the word. Chemotherapy and the application of collapse therapy, including major surgery, have improved the prognosis in these conditions, but the prognosis in the young adolescent is still grave, particularly when, with extensive bilateral pulmonary disease, the diabetic condition necessitates the intake of over 40 units of insulin daily.

I should also like to comment on the increase in the number of cases admitted to our wards for treatment of uro-genital lesions. Close co-operation is maintained with the surgical units in the treatment of such cases and our immediate results from chemotherapy have been good. This has been particularly

so in disease of the genital tract in the female and follow-up guinea-pig tests after treatment have been negative. In renal tuberculosis immediate results are also good and have in suitable cases made it possible for surgical treatment to be carried out. All such cases are closely followed up afterwards as it is fully appreciated that in a certain percentage positive findings recur later necessitating further chemotherapy.

Table 12 shows the waiting lists for the whole of the area covered by the East Cumberland Hospital Management Committee as at the 31st December, 1954, and the waiting list for the whole of the area for admission to one of the thoracic units for major surgery

The comparatively low sanatorium waiting list undoubtedly reflects a considerable measure of success in our fight against tuberculosis and compels us to consider afresh possible further requirements in this area.

At the present moment Blencathra Sanatorium is shared between East and West Cumberland on approximately a 50-50 per cent. basis. With the new developments in West Cumberland and the expected early provision of a 40-bed tuberculosis unit at Whitehaven, it is anticipated that the West Cumberland demands on Blencathra Sanatorium will diminish. We have also at present 12 beds taken up by East Cumberland patients at Meathop Sanatorium, which is outwith the Newcastle Region; these beds are urgently required by the Manchester Regional Hospital Board themselves, and I anticipate that when the West Cumberland demands on Blencathra Sanatorium diminish we shall be able to give up these Meathop beds.

It is probably unwise to forecast further developments beyond this. Both Ormside Sanatorium and Longtown Hospital have long since proved their usefulness, Longtown Hospital having acted as an ancillary unit to the chest ward at the City General Hospital, and Ormside Sanatorium being our most suitable hospital for the admission of non-infectious female cases, both pulmonary and non-pulmonary. Both these small hospitals have excellent tuberculosis beds. Blencathra Sanatorium itself is, I feel, somewhat overcrowded and when circumstances permit I should like to see the space allotted to patients there come into

the same category as the beds at Ormside and Longtown. This undoubtedly will mean a reduction in the number of beds at Blencathra Sanatorium.

One urgent necessity is the provision of a new chest ward at the City General Hospital; the present tuberculosis ward is well below standard and will require to be replaced by a new ward with facilities for the investigation of both tuberculous and non-tuberculous chest cases. The provision of a ward unit at this hospital is essential and as far as non-tuberculous cases are concerned our work had been, and is, seriously handicapped.

Facilities at the chest centre, good as they are, have become inadequate to cope with the large numbers of patients now attending at the centre and with their investigations, and the Regional Hospital Board have the matter of further accommodation actively in hand.

Much controversy has recently resulted in the medical press over the future place of the sanatorium in the treatment of cases of tuberculosis. The recent decision to close the Trudeau Sanatorium in the United States started this controversy, and it has gained considerable momentum from the fact that so many sanatoria in this country are situated in most inaccessible areas, thus tending to make the sanatorium a distinctly separate unit from the chest centre besides making it difficult for relatives of patients to visit. There is no doubt that were any sanatoria required to-day they would have to be built close to the main centres of population in an area. In East Cumberland, however, the chest centre and all our sanatoria and hospital beds are integrated into one single unit with the medical staff at the sanatorium doing regular duty at the chest centre, and vice-versa, thus ensuring close collaboration and the maximum benefit to the patients concerned.

The low waiting lists both for admission to sanatoria and the thoracic unit are indeed gratifying; not only does the individual patient benefit considerably by early admission, but it does allow the chest staff to embark on a definite programme of treatment, aiming, if possible, at complete cure. With the low major surgery waiting list one need no longer temporise with minor surgery and the result is that many

patients will be able to resume work at a much earlier date than we could promise previously.

Table 13 shows the number of cases dealt with at Seaham Hall Thoracic Unit during the year 1954. This unit opened in September, 1953, and the total number of cases done by the surgical team there from the date of opening until the time of writing—April, 1955—is given in parenthesis. The results of major surgery continue to be good, even in border-line cases which have been admitted for major surgery as a last resort.

The whole picture of therapy in tuberculosis is changing rapidly and a procedure which might have been advised in an individual case six months ago would to-day be substituted by another considered as giving better prospects of success. The number of artificial pneumothorax and pneumoperitoneum inductions has greatly declined, but these are still carried out in selected cases. Whereas in 1953 no less than 55 inductions were done in the chest ward here this number had dropped to 33 during 1954.

Our demands on the surgical unit have been heavy, but are now likely to remain on a reasonably steady level and may indeed diminish. Until now, one of the indications for major surgery has been the presence of a persistent cavity, but pathological and histological examinations of post-operative material have shown that some cavities which were undoubtedly previously tuberculous have become very thick walled and even lined by firm fibrous tissue as a result of medical therapy and are thus no longer a menace to the patient and his relatives. It is obviously bad treatment to advise surgery where there is no longer any need; one has obviously to assess with reasonable accuracy the state of a cavity before surgery is contemplated. Increasing use is therefore being made of tomography and bronchography, and I can well forsee that some patients may in future be discharged quiescent and able to work even in the presence of radiologically demonstrable cavities.

Table 12.

Waiting lists, as at 31-12-54
(Whole of the East Cumberland Chest Area)

	Males	Females	Children	Total
(a) for admission to hospital or sanatorium	13	10	3	26
(b) for admission to Thoracic Unit	9	3	—	12

Table 13.

	East Cumberland.		Carlisle City.		North Westmorland.	
	M	F	M	F	M	F
Thoracoplasty	6 (7)	5 (12)	5 (8)	5 (16)	— (1)	2 (2)
Resection	3 (4)	2 (3)	1 (1)	2 (2)	— (—)	1 (1)
Decortication	— (—)	— (—)	— (2)	— (1)	— (—)	— (—)
Extra Pleural Pneumothorax	1 (2)	— (—)	1 (2)	1 (2)	— (—)	— (—)
Pneumonectomy	1 (1)	4 (4)	— (1)	— (1)	— (—)	— (—)
Pleurectomy	1 (1)	— (—)	— (—)	— (—)	— (—)	— (—)
Lobectomy	— (2)	2 (2)	— (—)	— (—)	— (—)	— (—)
Totals ...	12 (17)	13 (21)	7 (14)	8 (22)	— (1)	3 (3)
	25 (38)		15 (36)		3 (4)	

Care and After-Care

The periodic examination of contacts has been continued during 1954 and much advice is given to patients and their families in co-operation with the local authority staff in preventing the spread of the disease. Patients continue to be admitted within a very short period after being first seen and on completion of treatment careful supervision is carried out until he or she is ready and fit for work.

Rehabilitation panels continue to be held every month at the chest centre and considerable time is spent in discussion in getting a fit patient into suitable employment. In this area no patient with a positive sputum is advised to return to work. Resettlement of patients who have had tuberculosis is not a difficult matter in this area; as a rule the psychological factor in allowing a patient to return to work is a favourable one and apart from work involving milk and milk products patients are encouraged to return to their previous employment if their physical disability permits this.

In other cases a course of training in a new occupation is instituted in co-operation with the Ministry of Labour and the occupation chosen is always one where the local Ministry of Labour can promise a local vacancy on completion of training. This is a most important factor as many patients, particularly those with family commitments, could not be peripatetic, or in the present housing shortage risk having to seek work in another part of the country.

Ambulance Service

Our calls on the ambulance service remain high largely because we continue to send patients home before their full period of graduated bed rest and exercise have been completed, thus enabling us to have a larger turn-over in our beds.

Other Chest Diseases

Bronchiectasis

The following table shows the number of cases of bronchiectasis on our active register at the end of 1954, the number of new cases coming on our register during the year, and the number of attendances for physiotherapy made by patients suffering from the disease.

	East Cumberland.			Carlisle City.			North Westmorland.		
	M.	F.	Ch.	M.	F.	Ch.	M.	F.	Ch.
On register 31-12-53	33	23	28	48	25	15	14	4	5
New cases during 1954	9	5	8	9	10	13	1	—	1
Total on Register 31-12-54	39	32	28	39	27	22	17	3	4
No. of attendances for physiotherapy	47	96	212	88	123	391	5	6	28

Full co-operation in their investigation is maintained with the thoracic surgeon and in a small number of cases surgical treatment has been carried out at Shotley Bridge Hospital. The results of treatment by physiotherapy continue to be good, and in many cases where this has been done conscientiously patients have improved so much that they no longer have cough or sputum and remain well.

Asthma and Bronchitis.

Full use is again made of the psysiotherapy facilities for the large number of children who are seen suffering from asthma and bronchitis. Older patients with chronic bronchitis and emphysema come into a slightly different category; whilst treatment in these cases remains essentially one of controlling the intercurrent inflammatory episodes by penicillin or other anti-biotic, some of these cases also appear to be improved as a result of physiotherapy. Patients with asthma particularly appear to respond well as even if there may be emphysema present this would appear to be reversible to some extent in these cases, whereas in chronic bronchitis the accompanying emphysema would appear to be more or less permanent.

Neoplasm.

The number of cases of pulmonary cancer seen and investigated during the year has risen and the whole problem here continues to be a most depressing one. Cases considered suitable for pneumonectomy are admitted to Shotley Bridge Hospital without delay and whilst our surgical colleagues tell us that 40 per cent. of such cases survive for a five year plus period this is a very small figure when judging the total number of cases seen. Only two out of the last 14 cases seen at the chest centre have been considered suitable for surgery.

There is no doubt that cancer of the lung is on the increase; whilst during the last 30 years some of this increase may be explained by better diagnosis and greater longevity of the population, figures in the last decade alone show that there has been an increase of about 160 per cent. One striking feature is that this increase in lung cancer has occurred whilst the incidence of common cancer in other sites, such as the stomach and rectum, shows no change or has even declined. It is well worth noting in considering the association of tobacco smoke and cancer that there has been a relative decrease in the incidence of cancer of the larynx.

Pulmonary cancer is much more common in men than in women in a ratio of about 6 to 1 and varies considerably in its malignancy. As a general rule the older the patient is the more likely is the lung cancer to be of the squamous cell type of tumour with a relatively good prognosis so far as years of life are concerned.

The high incidence of lung cancer in workers in the chromate industry has been noted elsewhere and there would also appear to be some increase in the incidence of cancer in iron-ore miners. Our cases here are drawn from all over the East Cumberland area and no increased incidence has been noted in any particular industry.

Controversy still exists as to the etiology of lung cancer. All one can say is that there is undoubtedly present some intrinsic carcinogenic factor and that the trigger mechanism firing it off, as it were, could be any irritant or local trauma.

Pneumoconiosis and silicosis.

Panels continue to be held at the chest centre in consultation with the Senior Permanent Member of the Pneumoconiosis Board. Most of these cases come from the West Cumberland area, but a few come from the Patterdale Valley in Westmorland and cases from the Alston and Newcastleton areas are also seen. The recent extension of the benefit schemes to workers who have left the industry for some considerable time has resulted in an increase in the number of cases seen. Close collaboration is also maintained with the pathological department as not the least interesting or important factor in this work is the study of the post-mortem material.

Other chest conditions.

During the year an increasing number of cases suffering from sarcoidosis have been investigated and some of these have been admitted for treatment. Confirmation of the diagnosis is usually made by gland biopsy and in certain of the treated cases there had been very considerable improvement.

A considerable number of patients present themselves with acquired diaphragmatic lesions which necessitate extensive radiological investigation and careful assessment as to whether major surgery would be likely to improve their condition.

Mass Radiography.

(Note: Figures given in brackets throughout the report relate to the corresponding figures for 1953)

The unit was fully operational throughout the twelve months. Considerably more time was spent in West Cumberland than in previous years and the opportunity was taken to visit many of the smaller townships and villages in the area which had not previously received a visit from the unit. The scheme whereby National Servicemen passed through the unit terminated in July as it was found impossible to arrange for regular weekly examinations of this group and National Servicemen are now dealt with by the Odelca unit at the Cumberland Infirmary.

Groups examined.

During 1954 the unit operated continuously throughout the Special Area and in addition to carrying out surveys at works and factories, surveys of the general public were carried out on 41 (29) occasions. 2,413 (1,407) contact cases were x-rayed, 1,839 from the East Cumberland area and 574 from West Cumberland. 314 National Service recruits were examined.

Towards the end of the year, by arrangement with the Medical Officers of Health concerned, facilities for x-ray examination were made available for all school children over the age of 13, this examination being complementary to the Mantoux testing and B.C.G. vaccination schemes of the local authorities. Full advantage was taken of the service as 4,329 (4,707) children of these age groups passed through the unit. It is to be noted that examination of school children is only carried out after receiving the consent of the parents.

The full co-operation of the general practitioners in the areas visited was invited during each survey and the number of persons referred by general practitioners increased from 267 in 1953 to 422 in 1954. The small number of persons so referred is not unexpected as medical practitioners have a very close liaison now with the chest centres both in East and West Cumberland and they refer such cases direct to the chest centres.

Sessions were held for members of the general public in 33 (24) towns and villages in the Special Area. Preliminary propaganda was carried out, including advertisements in the press, in local cinemas and by posters and handbills. These public sessions necessitated no prior appointment and were well attended, 20,217 (20,090) persons having passed through the unit.

Results.

During the year 44,471 (41,532) persons were examined by the unit. These included 1,124 (1,069) inmates of Dovenby Hall and Garlands Hospitals. Excluding the mental patients, 43,347 (40,463) civilians were examined of whom 20,776 (20,731) were males and 22,571 (19,732) were females.

Number recalled for full sized X-ray film—
1990 — 4.47% of total examined
(1832 — 4.41%).
Number referred for clinical examination—
599 — 1.35% of total examined.
(593 — 1.43%).
Number failing to attend for full sized film—
127 — 6.40% of those recalled.
(104 — 5.68%).

The detailed results of the x-ray examination are shown in Table 1.

Table 1.

	Male.	Female.	Total.	Percentage of total examined.
Abnormalities revealed.				
(i) Non-tuberculous conditions:				
1. Abnormalities of ribs etc.	65	80	145 (357)	.33 (.86)
2. Bronchitis & emphysema	105	93	198 (978)	.45 (1.59)
3. Bronchiectasis	27	34	61 (93)	.14 (.22)
4. Pneumoconiosis	134	—	134 (90)	.30 (.22)
5. Pleural thickening	149	73	222 (379)	.50 (.91)
6. Intrathoracic neoplasms	9	3	12 (9)	.30 (.02)
7. Cardiovascular lesions—				
(a) congenital	1	2	3 (3)	.007 (.007)
(b) Acquired	124	191	315 (335)	.71 (.81)
8. Miscellaneous	85	47	132 (173)	.30 (.42)
(ii) Suspected pulmonary tuberculosis.				
Previously known—				
1. Active	14	9	32 (13)	.05 (.03)
2. Inactive	4	6	10 (17)	.02 (.04)
Newly discovered—				
1. Active	52	74	126 (121)	.28 (.29)
2. Inactive primary	122	144	266 (416)	.60 (1.00)
3. Inactive post-pirmary	301	242	543 (414)	1.22 (1.00)

The number recalled for clinical examination included all persons presenting radiological evidence of possible active pulmonary tuberculosis, cases of bronchiectasis, particularly those in the under 35 age groups, all neoplasms and many of the persons presenting iron ore and pneumoconiotic changes in the x-ray pictures. Clinical examinations were carried out at the chest centres.

Table 2 gives a detailed analysis of the work of the unit divided into the East and West Cumberland areas :—

Table 2.

EAST CUMBERLAND									Source of examination.	WEST CUMBERLAND								
Miniature Films.	Large Films.	Clinical Exams.	Active T.B.	Inactive T.B.	Bronchiectasis.	Neoplasms.	Pneumoconiosis.	Cardiac Conditions.		Miniature Films.	Large Films.	Clinical Exams	Active T.B.	Inactive T.B.	Bronchiectasis.	Neoplasms.	Pneumoconiosis.	Cardiac Conditions.
151	33	14	3	9	4	—	—	5	Doctors' cases ...	271	58	34	7	28	4	1	8	5
247	9	1	—	1	—	—	—	1	Ante-natal cases ...	27	2	2	1	1	—	—	—	—
1,839	64	15	2	36	1	—	—	9	Contact cases ...	574	67	19	5	36	1	—	3	3
314	13	1	—	9	—	—	—	—	National Service Recruits	—	—	—	—	—	—	—	—	—
2,352	39	7	—	10	4	—	—	1	Scholars	1,977	52	15	7	20	1	—	—	3
284	10	—	—	5	—	—	—	—	School Staff	43	1	—	—	2	—	—	—	1
9,209	409	101	19	162	11	6	1	111	General Public .	11,008	569	220	62	202	14	4	120	78
8,713	360	82	10	181	16	—	—	60	Surveys	6,338	217	57	16	87	1	1	2	8
829	69	29	15	25	3	—	—	30	Mentally defective patients	295	18	2	2	5	1	—	—	3
23,938	1,006	250	49	438	39	6	1	217	TOTALS	20,533	984	349	100	381	22	6	133	101

Comments.

The number of persons passing through our unit has increased during 1954. During 1953 a slightly smaller proportion of the unit's time was spent in West Cumberland as the chest centres there were only becoming fully organised; as a result of our findings in 1953 that there appeared to be a greater incidence of tuberculosis in the West Cumberland area, the proportion of time spent in West Cumberland during 1954 was very greatly increased, 139 days being spent there as against 109 days in the East Cumberland area. This increased time in West Cumberland has resulted in a very satisfactory increase in the total number of examinations carried out and it is satisfactory to note that whilst the time in the East Cumberland area has been drastically cut this has not been reflected by a reduction in the number of examinations in this area, the number examined still exceeding those examined in the West Cumberland area. Indeed an increasing number of groups and individuals in the whole area are coming to look on a mass radiography examination at yearly intervals as a "must" and we are now in the happy position of having difficulty in fitting into the programme certain groups who want to be examined.

During the year the unit took a heavy load off the chest centres by examining a larger number of contacts. 1954 also saw the inception of the B.C.G. scheme in school children by the local authorities and the mass x-ray examination of these children which started towards the end of the year has progressed smoothly in full co-operation with the Medical Officers concerned.

During the year Mr. Ritchie and I have undertaken a series of intensive propaganda campaigns in the East Cumberland area aimed principally at securing a 100% response in the factories we visited. Unfortunately in spite of very careful preparation and highly concentrated effort about a week or ten days before the projected survey the results were most disappointing and the percentage response in the factories visited in this way while showing a slight increase did not nearly approach the 100% mark. There remains a hard core of workers in each factory who are either afraid to or will not pass through the unit during survey. Two redeeming features of our campaign were noticed however. On carefully checking our figures we found that

in spite of the small increase, a large number of the examinees had never passed through the unit before and we also discovered that a proportion of the employees who failed to attend while the unit was operating at the factory attended later at public sessions. Whilst naturally the total number examined in these factories gave rise to a keen sense of disappointment, the result of closer analysis makes us feel that the policy of carrying out mass radiography surveys in these factories at yearly intervals is fully justified. As the present older age groups retire and younger individuals who have previously passed through the unit whilst at school take their place in industry we should get eventually a 100% response.

Analysis of persons passing through the unit since it commenced operating in 1951 shows that of the total population of 300,000 in the Special Area, approximately 100,000 have passed through the unit. As very few children under the age of 13 were examined, this means that more than 40% of the adult population have availed themselves of the mass radiography service at some time during the past four years.

Mass radiography continues to be an integral part of the chest service and in examining large numbers of people is the most potent diagnostic agent at our disposal. I would again emphasise, however, that the results of this service cannot be assessed on the number of abnormalities found nor on the number of new cases of active tuberculosis discovered. Important though these figures are it is no less important to be able to give an assurance that so large proportion of the general public have normal chest x-rays.

Again, even in spite of a normal x-ray report, I must stress that should chest symptoms develop in an individual later, that individual should seek further medical advice from his own doctor. I make no apology for repeating this statement.

Acknowledgements

Once again it is a pleasure to acknowledge the valuable help received in the chest centre work as a whole from the staff of the Public Health Department and particularly I would express my sincere thanks to Dr. Kenneth Fraser, the County Medical Officer, for his continued valuable co-operation.

WEST CUMBERLAND

(Dr. R. Hambridge, Consultant
Chest Physician)

The early part of the year saw further development in both out-patient clinic facilities and provision for satisfying local needs for treatment.

Minor structural alterations to the St. Bridget's Lane County Health Clinic in Egremont to allow installation of x-ray plant adequate for routine chest clinic procedure were completed by June and the totally inadequate premises in Sandhills Lane, Whitehaven, have since then not been used. Some concern was felt that Whitehaven and district patients might find the five mile journey to Egremont inconvenient, but attendances at Egremont, despite the period when the clinic could not be used owing to building alterations, have shown this to be unjustified. In fact this clinic has handled two attendances for every three at the new Workington clinic, which, in view of the very cramped conditions at Egremont, for staff and patients alike, is a creditable record for such a pocket handkerchief clinic.

In October, the new county clinic premises in Millom were opened, and the small annexe designed for chest clinic purposes has been in use since then. Most patients in the Millom area have attended Egremont for x-ray purposes. Public transport lines make Barrow-in-Furness more acceptable to this southermost community of Cumberland, and the frequent and unfailing help of the x-ray department at the North Lonsdale Hospital is gratefully acknowledged.

Work on the much needed road to the Workington Chest Clinic was begun in the late summer and though unfinished at the end of the year, has since been completed to the great convenience of patients and staff.

The allocation of additional beds at Ellerbeck, mentioned in the annual report for 1953, was duly completed with some improvements in ward and patient sanitation. A servicable x-ray screening and treatment room was installed, and a high bed occupancy has been maintained throughout the year. Slightly more extended use of unoccupied fever hospital beds at Galemire has been made during 1954 and the total of patients treated in institutions during the year shows a slightly higher figure for the proportion treated in West Cumberland, as distinct from those who were admitted to more distant sanatoria — Blencathra, Hexham and Poole.

The year has been predominantly one of putting into operation, on a practical scale, facilities planned for and established during 1952 and 1953. As will be seen from the details following, attendances at the three clinic premises in West Cumberland have again increased, and with the exception of Millom much duplication of visits avoided by having x-ray facilities available in the same building and concurrently with the consultative and contact clinic sessions.

Case Finding Methods

The M.M.R. unit operated in this area on a slightly more extended programme during 1954. With an increased total attendance of 20,561 persons, 100 fresh cases of active disease were disclosed—a rate of 4.8 per thousand examined, which is almost twice as high as the rate for the Newcastle Region. The unit's activities produced 42% of fresh cases notified during the year.

General practitioners referred 63 new cases, representing 28% of new notifications; contact examination at clinics revealed 28 cases of active disease, and 26 cases were referred from the wards of the general hospitals—each approximately 12.5% of new cases notified.

In addition, from May onwards a gradually increasing proportion of ante-natal cases were x-rayed as a routine at Workington Infirmary, Workington Chest Clinic, Whitehaven Hospital and Egremont Chest Clinic: these disclosed 4 cases of active disease from a total of 307 ante-natal cases. A further 27 ante-natal cases were seen at M.M.R.

Referrals from industrial organisations with x-ray facilities, school medical officers, and Her Majesty's Forces, each contributed about 1-2% of the total new cases.

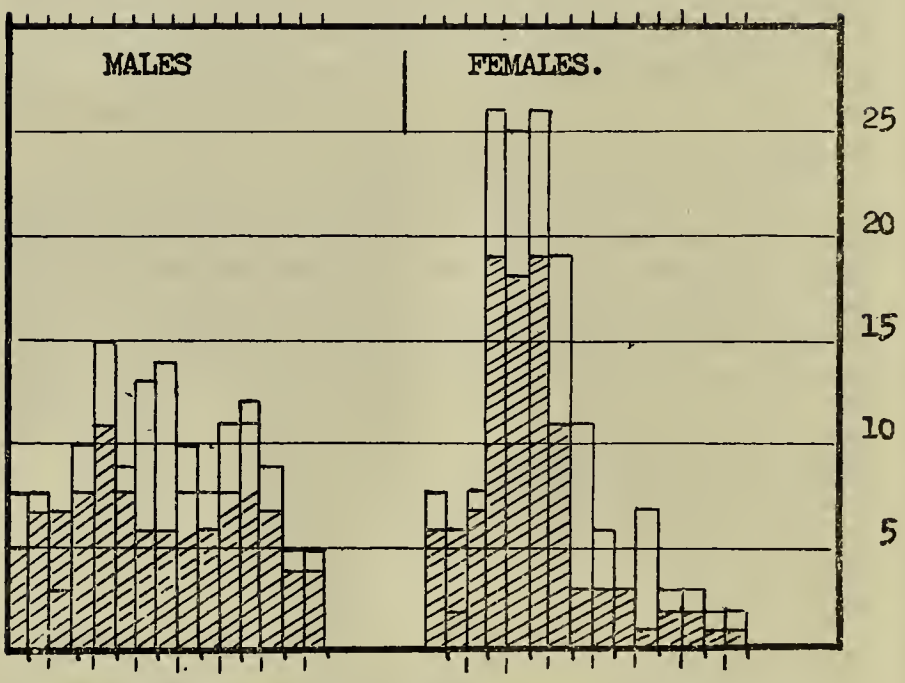
Towards the end of the year, Mantoux testing of school entrants was undertaken by the medical staff of the county medical authority; examination of the adult contacts of children found infected is proceeding, but no fresh cases were identified during 1954 from this source.

Tuberculosis Notifications

The total of fresh notifications for the year is 224 —a decrease of 57 on the 1953 figure. This decrease is again more apparent than real owing to the time-lag between diagnosis and notification: from clinic records it appears there is little change in the case rate for 1954 from the previous two years. It should be noted, however, that a more extensive case finding programme has operated during 1954, and the proportion of fresh cases diagnosed when in an advanced state of disease is one of the lowest figures in the Newcastle Region. The case rate of 1.61 is based on notifications made and is comparable to the rates of 1945/50.

The following graphs indicate notifications according to 5 year age groups and again show the same tendency as shown in 1953 for tuberculous disease to be spread fairly evenly over all ages of males but for a distinct peak to exist in females aged 19-35 years. There is again a relatively high proportion of fresh cases in the under 15 years group suggesting an undesirable amount of unrecognised or uncontrolled disease in parents or family circles.

GRAPH I : FRESH NOTIFICATIONS 1953 and 1954.



AGE IN 5 YEAR GROUPS.

▯ = 1953

▨ = 1954

TABLE I.

FRESH NOTIFICATIONS, 1954: BY AGE GROUPS OF 5 YEARS

Sex	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+		Total
Male	4	7	7	10	11	8	6	6	8	6	8	12	9	5	5	...	112
Female ...	6	6	8	24	13	19	19	3	5	3	1	2	2	—	1	...	112
Total	10	13	15	34	24	27	25	9	13	9	9	14	11	5	6	...	224

Tuberculosis Register

There has again been an increase in the total number of known cases of tuberculosis in West Cumberland. On the 1st January, 1954, 1,219 cases remained on the register from the previous year: with the increment of fresh notifications, cases previously lost sight of but returning to the clinic during the year, and children attaining adult age groups, the register rose to 1,525, from which deaths, recovered cases, transfers out and altered diagnoses caused a reduction to a final figure of 1,434 cases remaining on the register at 31st December, 1954. Thus a net increase of 215 cases occurred.

The number of known cases per thousand population in this part of Cumberland is now 10.3 compared with 9.04 in 1953 and 7.53 in 1952.

Treatment

Of the total number of cases quoted above, treatment was deemed necessary in roughly one third. Beds have been freely available for immediate admission almost constantly throughout the year. Waiting for a bed is now synonymous with a patient's refusal to accept the first immediate vacancy at any one of the three main centres for treatment, viz.:—

Blencathra Sanatorium, Ellerbeck Hospital, Galemire I.D.H.

While 93 patients were admitted to more remote sanatoria, 103 were admitted to Ellerbeck and Galemire. Admissions to Seaham Hall for major surgical procedures totalled 48—18 men and 30 women—and it was noted that 23 patients refused admission anywhere for treatment. The growing belief that tuberculosis can be adequately treated at home has undoubtedly been largely responsible for a further 236 cases attempting treatment along these lines. A review of these cases, however, shows that 45% are found to require further immediate treatment either in the form of more prolonged rest with chemotherapy or additional measures for control of the diseased part for which admission has been necessary. Of those patients admitted (196) 17 took their own discharge against medical advice and before adequate control of their disease was established. It appears that while most patients are willing and able to accept the medical

recommendation offered, a large number either will not or cannot do so, or, if they attempt it, fail to see it through—which consideration must offset the growing optimism which a continually declining death rate has falsely engendered. The concept of tuberculosis being a disease rapidly assuming neligible proportions can only be held by those who measure it in terms other than the return of the patient to his normal vocation in health and security.

The following table sets out the number of admissions to sanatoria/hospitals from the several sanitary areas in West Cumberland : —

Workington	58
Whitehaven	23
Cockermouth	20
Maryport	30
Ennerdale	56
Millom	9

Out-Patient Collapse Therapy

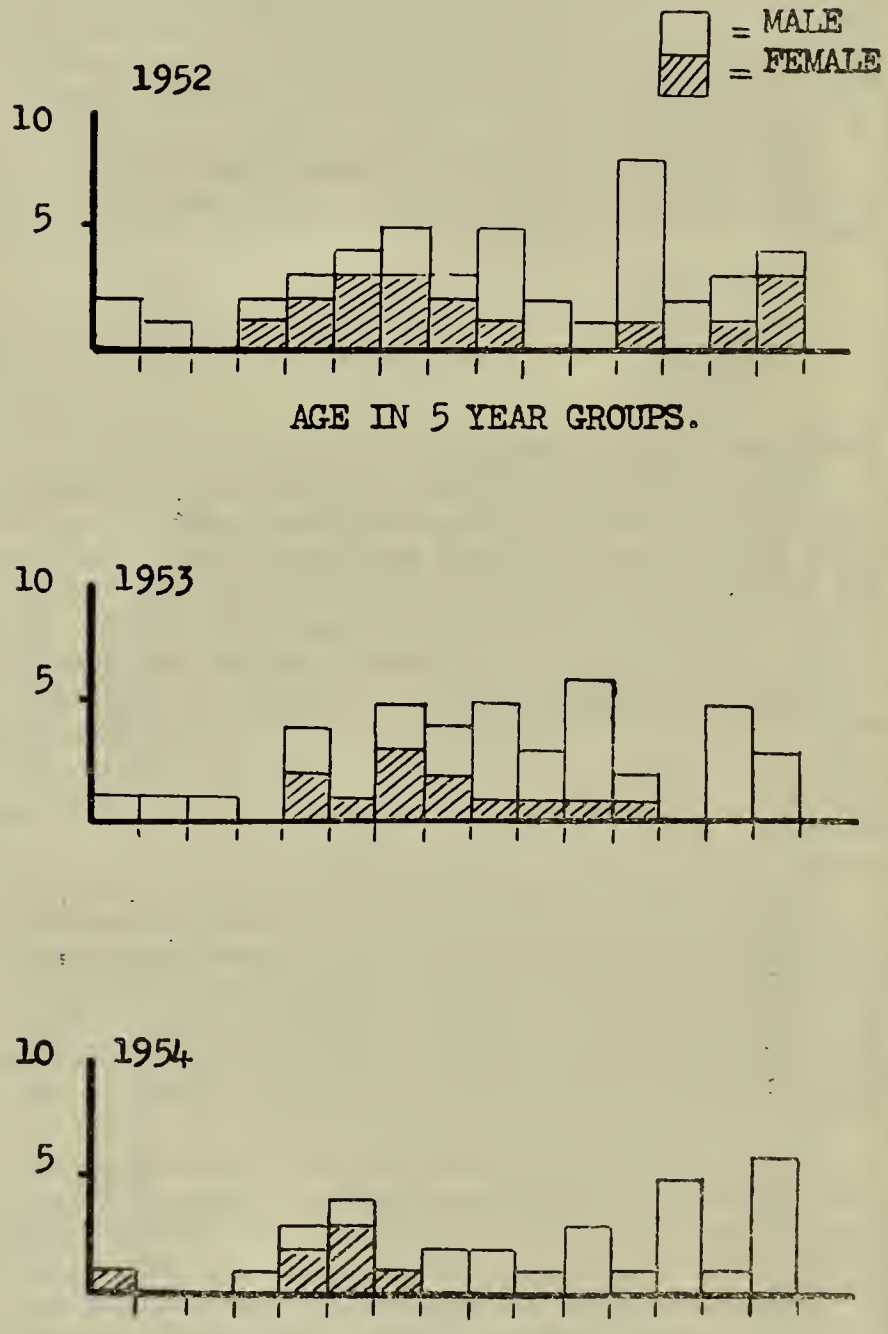
The refill clinic sessions have been held unchanged from the rate for 1953. The register of patients undergoing this form of treatment again totals 185, the average weekly attendance of 96 being slightly lower than 112 for 1953. Two refill sessions have been held each week. The stability of the register suggests that a peak was reached during 1953/54 in this form of treatment which, with the continuing service for major thoracic surgery available at Seaham Hall, may now slowly decline if more definitive forms of treatment can be employed.

Deaths

During the year 25 deaths were recorded in persons suffering from all forms of tuberculosis, giving a mortality rate of 0.18 per thousand, which rate is less than the average for the Newcastle Region, but remains still above the national average. This rate is about one fifth the figure for 1945 (0.99) and one third that of 1950 (0.67).

From the following graphs it can be seen that the main reduction in deaths in recent years has been in the younger age groups; whereas in 1952, 55% of the total deaths occurred in persons 45 years and under in 1954, 40% fell in this age bracket. Further, the main decline has taken place amongst women who in 1952 contributed nearly 40% of the total, but in 1954 78% of the total deaths occurred in males.

GRAPH II
TOTAL DEATHS FROM TUBERCULOSIS, ALL FORMS, FOR EACH YEAR.



An analysis of the deaths which occurred shows that of the the total 25, 4 cases were notified at or after death: 8 were associated with iron or coal miners' pneumoconiosis; 2 had associated cancer and 3 were due to non-respiratory forms of tuberculosis. Of the remainder, 8 cases had far advanced disease at diagnosis during or before 1948.

In the Special Area, i.e., East Cumberland, West Cumberland and North Westmorland, the proportion of deaths from tuberculosis occurring in West Cumberland is again lower being approximately 55% of the total for the area, compared with 63% for 1953, 70% for 1952, and 80% for 1951 and earlier.

There can be little doubt that this trend underlines the need that existed in 1951 for adequate facilities for diagnosis and treatment locally; and from the data given in the analysis of deaths, it can be seen that the majority of fatal cases are now either aged persons or cases of pneumoconiosis, i.e. cases in which diagnosis has been equivocal or delayed; and in most of these treatment has been inadequate either because of the delay in diagnosis or the patients' inability to accept treatment recommended.

The mortality rate for respiratory tuberculosis was 0.16 per thousand, the lowest yet recorded in West Cumberland.

Pneumoconiosis

While the mortality for tuberculosis has sharply declined in this area, no similar trend can be seen in the available statistics for sufferers from pneumoconiosis. A constant number of deaths due to combined pneumoconiosis and tuberculosis occurs annually: of these, in each of the past three years, half the cases have apparently not been suspected of suffering from the dual condition at any time prior to death. Diagnosis has only been achieved at autopsy: and in most cases compensatable disability has been known to exist by the Pneumoconiosis Panel and the patient's general practitioner for several years prior to death.

Despite the differing views held as to the cause of advanced pneumoconitic changes seen on chest x-ray, the following figures so far as West Cumbrian miners are concerned indicate a frequency of co-existing

tuberculosis at death which cannot be gainsaid. These figures have kindly been made available by Dr. J. Egan of the Pneumoconiosis Panel.

In 75 consecutive autopsies of cases of pneumoconiosis, 20 showed no evidence of tuberculosis; 17 showed histological evidence of pneumoconiosis with tuberculosis; 2 were found to be pure tuberculosis; and in 36 cases neither tuberculosis nor significant pneumoconiosis were found. No bacteriological study of autopsy material was made.

A similar set of findings has recently been reported by Dr. J. Steven Faulds of the Department of Pathology Cumberland Infirmary, Carlisle, in which, in 163 consecutive autopsies histological evidence of tuberculosis was obtained in 42% of cases of pneumoconiosis where the average age at death was 57 years.

By far the largest number of cases of pneumoconiosis with tuberculosis occurs in iron-ore miners, the majority of which have long since ceased active mining. Despite the many cases known to the chest clinics in this area, there must be many more such in the community steadily progressing towards fatal tuberculosis for which no measures to control their disease have yet been taken owing to failure to recognise the possible tuberculous background to their pulmonary disorder, and failure to institute appropriate treatment when there is a reasonable prospect of success.

Of much happier augury is the remarkable fall in deaths from tuberculosis in childhood. (During 1954 only two cases below the age of 20 died—both clinical problems of unusual interest. One infant succumbed, 48 hours after hospital admission, to widespread disease at the age of 5 weeks, infected with an overwhelming process probably within the first few days of life.) The high level of diagnostic and therapeutic skill available in paediatric tuberculosis is solely responsible for this state of control, as it will be seen from the notification tables that children and infants in West Cumberland still run the same risk of disease as in previous years, and in fact fall ill with the same frequency and severity.

Contact Examinations

With additional clinic accommodation and x-ray facilities, a considerable increase in this routine work has been effected. Some 214 adult males and 459 adult

females were investigated at contact clinic sessions, none of these contacts being previously seen. A further 1,251 adults were referred to the M.M.R. Unit of which 574 are known to have attended. Children examined numbered 845. The case rate from amongst contacts seen was 28 per thousand, indicating a much higher rate of find than, for instance, the case rate observed with M.M.R. activities in the general public, which for West Cumberland in 1954 was 4.8 per thousand.

The total of contacts seen at clinics:

1,537 compared with
1,245 for 1953 and
249 for 1952.

and the ratio of new contacts seen to new cases diagnosed is 1,537: 224, or approximately 7 : 1.

B.C.G. Vaccination.

More than twice as many children from amongst the contact population have been vaccinated as in the previous year. Of 845 children tested, aged 15 and under, 567 were given B.C.G. The previous years' figures are:

1950 and 1951 combined — 60 vaccinated
1952 — 87 ,,
1953 — 224 ,,

The larger number of children found non-reactors to 1/1000 O.T. is not so much an indication of a falling rate of infection, as a measure of more extensive contact work amongst the families and residential contacts of known cases. During the latter part of 1954, a tuberculin survey of school entrants disclosed a generally high reactor rate for this young age group in West Cumberland; and in some areas, notably the Egremont, Cleator Moor and Frizington areas, it appears one child in every six has been infected by the time it begins school. Such a rate of infection demands special consideration, for in these areas, tuberculosis —known and unknown—is obviously so rife as to make B.C.G. vaccination probably of extremely limited value unless used in early infancy.

Chest Clinic Attendances:

A further slight increase in attendances occurred at three of the four clinics during the year: at Work-

ington, however, attendances increased markedly, and at the end of the year the only limiting factor on attendances was the time which x-ray technical staff could be spared for chest clinic purposes.

Attendances for consultative sessions:

Workington	3,027	(1,874)
Whitehaven (at Egremont)	1,280	(1,027)
Egremont	883	(826)
Millom	257	(253)

(Figures in brackets refer to 1953.)

It can be seen that the transfer of Whitehaven sessions to the Egremont Clinic premises has not caused any marked decline in attendance rate; and had building alterations not seriously interfered with sessions at Egremont for some months, a higher total attendance for both Egremont and Whitehaven would have ensued.

The average attendances per session for the four clinics are:—

Workington	21
Whitehaven	14
Egremont	19
Millom	15

As mentioned previously the refill clinic attendances were of the same order as for 1953, the average per session being 48, there being two sessions weekly.

Total Clinic Attendances for 1954: 10,383, of which 7,963 were conducted at Workington Chest Clinic.

Mass X-Ray Unit.

Following last year's analysis of the unit's work, an increased working time was spent in West Cumberland during the year. A summary of the unit's work follows:

TABLE II.

MASS MINIATURE RADIOGRAPHY IN WEST CUMBERLAND, 1954

Source of Examination.	Miniature films.	Large films.	Clinical Exams.	Active T.B.	Inactive T.B.	Bronchiectasis.	Neoplasms.	Pneumoconiosis.	Cardiac Conds.
Doctors' Cases	271	58	34	7	28	4	1	8	5
Ante-natal Cases	27	2	2	1	1	—	—	—	—
Contact Cases	574	67	19	5	36	1	—	3	3
National Service Recruits	—	—	—	—	—	—	—	—	—
Scholars	1977	52	15	7	20	1	—	—	3
School Staff	43	1	—	—	2	—	—	—	1
General Public	11008	569	220	62	202	14	4	120	78
Surveys	6338	217	57	16	87	1	1	2	8
Mentally defective patients	295	18	2	2	5	1	—	—	3
TOTALS	20533	984	349	100	381	22	6	133	101

Some 5,000 people more than in 1953 passed through the unit, but the total attendance was still less than occurred in East Cumberland—46 per cent. of all attendances in Cumberland. Nevertheless, in this 20,553 group, 100 fresh cases were identified, constituting 68 per cent. of fresh cases found by the unit in Cumberland during the year. Although the attendance rate was comparatively low for the additional time spent, the increased yield of the units' activities appears to have justified this fully.

The Welfare Services

I am indebted to the County Welfare Officer (Mr. Walker) for the following report on the Welfare Services, the administration of which is in the hands of the Welfare Sub-Committee of the Health Committee.

NATIONAL ASSISTANCE ACT, 1948

Care of the aged in their own homes.

One important principle which is constantly stressed in connection with the welfare of aged people is that such persons should be encouraged to live a normal life in their own homes for as long as possible, and be provided with such services as may be necessary in order to enable them to do so. The services in question are those of (a) a statutory nature such as (i) the provision by Housing Authorities of small dwellings of the bungalow type and/or where possible and justified, schemes of flats managed jointly by a Housing Authority and a Voluntary Organisation (such as the W.V.S. or an Old People's Welfare Committee); (ii) National Assistance grants to supplement retirement pensions where the latter are inadequate to meet day to day needs; and (iii) Home Helps, etc., provided through the County Health Committee to lighten the load of the somewhat irksome household duties which, in the absence of help, are inclined to get beyond the capacity of the old people, and (b) those of a voluntary nature such as are provided through the medium of Old People's Welfare Committees. Keeping that principle prominently in mind, close co-operation is established with the various departments of the County Council, the Local Authorities, and the Cumberland Old People's Welfare Committee whose policy is to establish Local Welfare Committees in the more urbanised districts in the County and to develop and expand in the rural areas the novel scheme of "old people's friends" established some 2 years ago with the much valued co-operation of the Federation of Women's Institutes.

Part III Residential Accommodation—Needs and Policy (Present and Future)

Due to advancing years, infirmities and other considerations, many cases do arise, and with an ageing population will continue to arise, where the need for something less exacting than the running of an independent household becomes apparent, and it is in connection with these cases that in previous reports emphasis has been on the urgent and increasing need to provide more modern type residential accommoda-

tion wherein elderly people in need of care and attention can, without worries (mental, physical and financial) enjoy their remaining years free from any fear of insecurity and deficiency of attention.

The number of aged infirm and handicapped persons for whom residential accommodation is required is given in the County Council's Provision of Accommodation Scheme as 400.

To ascertain the extent to which modern type hostels would need to be provided, an investigation showed that approximately 22.5 per cent. of the residents at that time consisted of persons who on account of anti-social tendencies, unclean habits, etc., would not fit into modern hostel life and for whom institutional accommodation (upgraded from the old Poor Law standards) would seem to be the only answer. Applying that percentage to the 400 persons for whom residential accommodation would be required on a long term policy, we get

(a) 90 persons for whom institutional accommodation would still be necessary; and

(b) 310 persons who would be suitable for modern type hostels.

The County Council have already embarked on a policy of providing by stages modern type residential accommodation of the kind envisaged by the Act, one home (Grange Bank, Wigton) for 19 elderly females being opened on the 1st April, 1953, whilst another one (Derwent Lodge, Papcastle) for 18 elderly males was opened on the 1st January, 1955.

During the year ended 31st March, 1955, it is very pleasing to record further progress in the extension of that policy by

(a) the acquisition and adaptation of premises in Whitehaven known as "Sorbie and Garlieston" to provide residential accommodation for some 32 elderly males and females, and which it is hoped to open before the Autumn of 1955;

(b) the purchase of a small mansion known as "The Croft," Kirksanton, which, when adapted, will provide residential accommodation for some 16 elderly males and females from and around the Millom area (i.e., the southern part of the Administrative County)—plans for the conversion having already been submitted for the approval of the Ministry of Health; and

(c) the inclusion in the Capital Building Works Programme for the approval of the Ministry of Health schemes for the erection of two mixed homes of 35 beds each—one in Workington and one in Maryport on sites to be later agreed—at an estimated capital cost of £30,000 each.

Whilst it is interesting to also record that applications for places in the new homes mentioned at (a) and (b) are already coming in and a waiting list is being compiled, it is becoming increasingly evident that it is the new type of home which makes a definite appeal to elderly persons in need of care and attention, as being above the level of the former Public Assistance Institutions in which they are not prepared to end their days, regardless of the somewhat impossible and insurmountable difficulties which may exist or arise in maintaining independent homes of their own. This position reminds me of a statement made in last year's report to the effect that when the modern type of residential accommodation becomes more freely available, there would be a greater demand for it from those classes of elderly persons who are at present deterred by the institutional atmosphere of establishments such as Meadow View House, Whitehaven.

On this question of residential accommodation, one must not overlook the additional duty imposed on the County Council of providing temporary accommodation for persons who are in urgent need thereof, being need arising in circumstances which could not reasonably have been foreseen, or in such other circumstances as the Council may in any particular case determine. Under this heading one has in mind persons who may be evicted from council and other houses for non-payment of rent and other considerations, and other persons rendered homeless through fire, flood, water, &c., who could not be regarded as in need of permanent care and attention by reason of age, infirmity, etc. Without going into too deep detail regarding this category of homeless persons, some accommodation must be available to meet any need which may arise.

On a long term plan, and on completion of the overall policy of providing the requisite amount of Part III accommodation for the aged and infirm, it is considered that temporary accommodation for other

homeless persons could be made available to the extent of 15 beds each at Station View House, Penrith, and Highfield House, Wigton.

Assuming, therefore, the eventual closing of Meadow View House, Whitehaven (an Institution built over 100 years ago) and the retention within the County scheme of Station View House, Penrith, and Highfield House, Wigton, Part III accommodation (permanent and temporary) in the Administrative County would be to the following pattern, viz.:—

	Residential Accommodation	Temporary Accommodation
(a) **Former Institutions**		
Station View House, Penrith ..	45 beds	15 beds
Highfield House, Wigton ...	45 ,,	15 ,,
(b) **Modern Type Hostels—**		
Grange Bank, Wigton ...	19 ,,	
Derwent Lodge, Papcastle ...	18 ,,	
Sorbie & Garlieston, Whitehaven	32 ,,	
The Croft, Kirksanton ...	16 ,,	
New Hostel, Workington ...	35 ,,	
New Hostel, Maryport ...	35 ,,	
	245 ,,	
Additional hostels to be established in other parts of the County, subject to appropriate timing and dependent on financial and other considerations ...	155 ,,	—
Total	400 beds	30 beds

[Total estimated accommodation as per County of Cumberland (Provision of Accommodation) Scheme, 1948.]

with, in addition, a short term hostel of 35 beds to give a measure of respite to hard pressed relatives looking after aged and infirm parents, and to be used also as a holiday home for Part III residents, a scheme already approved in principle by the Welfare Committee in 1951, and for implementation at the appropriate time.

In my last report I also said that an extension of the policy of providing modern type homes would not only be in keeping with the spirit of the act, but would secure economies in maintenance and administrative costs. In support of that statement, the information given below as to the gross cost per resident week

in the year ending 31st March, 1954 (excluding central administration, expenditure charged to special funds, the Regional Hospital and National Assistance Boards, loan charges and capital items charged to revenue) will be of interest, viz.:—

(a) Old type of institution—		
(i) Station View House, Penrith	£4 2 1	per week
(ii) Meadow View House, Whitehaven	£4 9 5	,, ,,
(iii) Highfield House, Wigton ...	£4 17 8	,, ,,
(b) Modern type of small Home for the aged—		
Grange Bank, Wigton ...	£3 12 8	,, ,,

For purposes of the net charge on rates, the above amounts would be substantially reduced by way of income from residents' contributions (which vary from the "minimum" to the "standard" charge), repayments by other Local Authorities and other income.

Meadow View House, Whitehaven
Hospital Section—Subsidence and Alternative Accommodation

In last year's report I made reference to the most unfortunate position which had arisen at Meadow View House, Whitehaven, where, due to the sudden occurrence of subsidence at the hospital block in June, 1954, the whole of the chronic sick patients had to be evacuated and transferred elsewhere. The sinking of boreholes showed that the hospital had been erected on the site of an old mine. Subsidence still continued and an expert mining engineer was engaged to make a comprehensive investigation. Preliminary reports have been received, but whether the affected part of the building (i.e., the centre portion) can be restored or rebuilt, and if so at what cost, has not yet been determined. A further important point would be as to the purpose for which the building, if restored, would be used, in view of approval given by the Ministry of Health to the plans of the Hospital Board's Special Area Committee for the building of a new hospital in West Cumberland. The sinking of further boreholes has been authorised and the future of the block cannot be resolved one way or another until the final report of the expert has been considered.

The enforced closing down of some 90 beds for chronic sick patients created considerable anxiety

throughout the area, both with regard to the emergency arrangements for the transfer of the patients to hospitals outside the county, and the future provision for such persons in West Cumberland. In order to give the utmost help possible, the County Council offered the Hospital Board the use of the male infirm block (a self contained unit at Meadow View House) which, subject to certain adaptations, etc., would provide about 30 beds for chronic sick patients in addition to the 40 beds the Board were to temporarily make available at Holmwood House, Whitehaven. The Hospital Board gratefully accepted the offer as a temporary expedient for 3 years in the first instance; adaptations and re-equipment were put in hand, and a unit of 31 beds was opened on the 28th March, 1955, for the reception of patients.

Highfield House, Wigton

Hospital Section—(a) Improvements, (b) Additional Beds

During the course of the improvements and adaptations to the hospital at Highfield House, Wigton, 20 chronic sick patients were for a period of 18 months temporarily accommodated in the former casual ward block. The improvements, etc., were completed in October, 1954, and the hospital, now a compact and pleasing unit of 35 beds, was re-opened on the 1st November, 1954, the temporary occupation of the former casual ward being brought to an end. In connection with the re-organisation being carried out at Highfield House under the planned policy of residential accommodation for aged and infirm persons, it was intended that the former casual ward block should be used as temporary accommodation for evicted or other homeless families. Notwithstanding the use of the male infirm block at Meadow View House, Whitehaven, for 31 chronic sick patients, and the re-opening of the hospital block at Highfield House for 35 persons, the shortage of chronic sick beds in West Cumberland had deteriorated so much that the Hospital Board's proposals for obtaining additional beds meant the transfer of geriatric cases from East and West Cumberland to isolated accommodation outside the county, and made impossible the return to West Cumberland of some of the patients who were transferred to hospitals on the East Coast on account of the subsidence at Meadow View. In view of the difficulties and hardship being

caused to patients, and in a further effort to be helpful, the Hospital Board were authorised to carry out such adaptations to the former casual ward at Wigton as would make possible the addition of some 15 beds to the hospital's normal complement of 35 beds. Whilst the building is not yet in use as an annexe to the hospital, the adaptations, etc., being incomplete, it is understood as between the Hospital Board and the County Council that if the Council find themselves in difficulties with regard to accommodation for evicted or homeless families, the position would be re-examined, and if no solution could be found, the building would be returned for the Council's use. Hereon it may be mentioned that enquiries are proceeding regarding the availability of huts on a former camp site, and their use as temporary accommodation for homeless families.

General Comment.

Difficult, therefore, as was the hospital bed provision for chronic sick patients, the co-operative effort of all concerned in making available some 86 additional beds, will tend to lessen the considerable anxiety felt in West Cumberland by the closure of the hospital block of some 90 beds at Meadow View House, Whitehaven.

As evidence of the ever growing concern in problems relating to the care of elderly infirm and chronic sick, it would be appropriate to here mention that some twelve months ago the Local Joint Health Consultative Committee set up a working party, of which the writer of this report is a member, to consider the problems, the actual terms of reference being

(a) the study of the proposals for achieving closer co-operation between the various Authorities responsible for the care of the chronic sick and elderly infirm as set out in the report of the Central Health Services Council issued in 1952; and

(b) to examine and report on the principal obstacles to providing a wholly satisfactory service for the chronic sick and elderly infirm, and to make such suggestions and recommendations as may be considered practical and desirable to alleviate the present difficulties.

The investigations have been concluded and the working party's report and recommendations, which will shortly be issued, will merit the close and careful consideration of the local statutory authorities and

voluntary organisations concerned with the welfare of the aged, be the latter in need of accommodation in residential homes or, as chronic sick patients, in need of expanded or additional domiciliary services or treatment in hospital.

Present Part III Accommodation and Hospital Facilities for Chronic Sick.

Part III residential accommodation is at present provided in three establishments (attached to which are small hospitals or sick ward blocks catering in the main for the chronic sick) and two modern hostels. The establishments are:—

		Number of beds.					
		Part III. Accommodation			Hospital		
No.	Establishment	Males	Females	Total	Males	Females	Total
1.	Station View House, Penrith	27	15	42	16	16	32
2.	Highfield House, Wigton	50	19	69*	17	18	35
3.	Meadow View House, Whitehaven ...	127	67	194	16	15	31
4.	Grange Bank, Wigton	—	19	19	—	—	—
5.	Derwent Lodge, Papcastle ...	18	—	18	—	—	—
		222	120	342	49	49	98

*At present overcrowded. Position under review.

As the predominant user of the three former Institutions (1 to 3) prior to 5th July, 1948, was for other than hospital purposes, they remain wholly vested in the County Council.

The upgrading of the three institutions at Penrith, Wigton and Whitehaven has proceeded quietly and effectively, but the final re-arrangements at Highfield House, Wigton, could not be clearly defined until the structural alterations to the hospital were completed and re-occupation of the building was possible, and a number of the more suitable male residents were transferred to the new home at Papcastle, Cockermouth, thereby relieving the present overcrowding and enabling upgrading to take final shape. Pending cessation of user by the R.H.B. of the hospital block at Station View House, Penrith, which at the appropriate time would be converted for use as additional residential accommodation, the upgrading of Part III accommodation has been completed. The upgrading

of the Part III accommodation at Meadow View House, Whitehaven, has also been completed so far as the same was reasonably possible having regard to the rambling nature of the building. On the latter point, Ministry of Health Inspectors have often expressed the view that the building itself (built in 1854) could never form part of any long term policy of Part III residential accommodation. That is also the considered view of the Southern Area House Committee who recently urged the Welfare Committee to consider the immediate expansion of the policy of providing small type modern hostels, as in the opinion of the committee such expansion would, whilst securing economies in maintenance and administration costs, bring to an end the barrack-like or institutional atmosphere which is associated with such like premises as Meadow View House.

The following table shows the number of admissions and discharges during the twelve months to the 31st March, 1955:—

	Station View House, Penrith			Highfield House, Wigton.			Meadow View House, Whitehaven.			Grange Bank, Wigton		Derwent Lodge, Papcastle	
	Part III	Hosp.	Total.	Part III	Hosp.	Total.	Part III.	Hosp. *	Total.	Part III.	Total.	Part III.	Total
Admissions ...	28	45	73	64	78	142	132	†60	192	10	10	18	18
Discharges ...	26	18	44	62	21	83	131	113	244	8	8	3	3
Deaths	—	22	22	—	42	42	3	10	13	—	—	—	—
Residents and Patients maintained on 31/3/55 ...	32	32	64	47	34	81	121	‡14	135	19	19	15	15

*5th July, 1954—Hospital closed on account of subsidence, all patients having been transferred to other hospitals in and beyond the county.

† Included in this figure are 9 births.

‡ 28th March, 1955 — Male Infirm Block adapted and brought into use as a 31 Bed Chronic Sick Hospital and 14 patients immediately admitted.

Charges for Accommodation

In accordance with the provisions of sect. 22(2) of the act, and in fixing the "standard charge" from the 1st October, 1954 (the charge then being £4. 7. 6 per week for the Part III section of joint user establishments and £3. 10. 0 per week for the modern hostel at Grange Bank, Wigton) consideration was given to (a) the continued rise in costs and (b) the fact that hitherto the charge did not allow for capital sunk in the buildings. The "standard charge" was accordingly fixed at £4. 13. 4 and £4. 6. 11 per week respectively for residents in (a) the joint user establishments and (b) the modern type hostel, the last mentioned charge being also applied to the modern hostel at Cockermouth which was opened on the 1st January, 1955. The rates will remain in force unil reviewed by the committee after considering the costing statement for the financial year ended 31st March, 1955. During the year ended 31st March, 1955, the total payments by residents amounted to £16,860, as against £14,555 for the year ended 31st March, 1954. In a few cases only did the respective Area House Committees find it necessary to write off small outstanding amounts as irrecoverable.

N.B. Under the National Assistance (Charges for Accommodation) (Amendment) Regulations, 1955, the minimum charge was increased from 21/- to 26/- p.w. as from 3rd August, 1953, and from 26/- to 32/6 p.w. from 25th April, 1955.

Monetary Recompense to Residents Rendering Assistance

Residents who voluntarily give a substantial measure of regular assistance in the running and maintenance of Part III accommodation, continue to have their accommodation charges waived up to a maximum of 10/6d per week for such period as the home committees may decide. In addition, each resident has an allowance of 6/6d p.w. (increased to 7/6d p.w. from 25th April, 1955) for personal requirements.

At the end of March, 1955, there were 29 males and 21 females receiving remissions of 2/6 or 5/- p.w., having regard to the measure of regular assistance given. The total remissions or reductions in collections amounted to £10. 0. 0., per week, or at the rate of approximately £520 per annum. The position in each case is reviewed monthly by the area house committees, when consideration is also given to new or other cases qualifying for inclusion within the arrangement.

Medical Attention

General medical supervision of the Part III accommodation is undertaken by the former medical officers, who are also responsible for the treatment of patients in the accommodation reserved to the Regional Hospital Board.

Residents have the right to select their own doctor and the matter of the capitation fee payable to the doctor lies between himself and the Executive Council appointed under the National Health Service Act, 1946. Chiropody services have been provided free of cost to the residents, who derive much benefit therefrom.

Holidays

Under the amenity provisions of the act, the County Council have, over the past five years, authorised a week's holiday at the seaside or other approved place, for aged residents in Part III accommodation. This holiday is arranged in the early part of the season, advantage being taken of specially reduced boarding rates offered to local authorities arranging holidays for old people. The holiday is of great benefit from a health point of view and is greatly appreciated by the old people.

Residential Accommodation Provided by Voluntary Organisations

The arrangement with the Carlisle Diocesan Council for Social and Moral Welfare, whereby residential or temporary accommodation was made available at Coledale Hall, Carlisle, for a like purpose as that provided by the County Council under the Part III provisions of the Act, operated to the advantage of the County Council, appropriate annual grants being made to the Diocesan Council, on the basis of records of county cases received into Coledale Hall. Due to staffing difficulties and other considerations, the Diocesan Council had no alternative but to close the home in October, 1954. The services were, however, restored in May, 1955, and the former arrangement with the County Council is again in operation.

Temporary Accommodation

Accommodation is at present provided at the only places available viz. Meadow View House, Whitehaven, and Highfield House, Wigton, and during the year ended 31st March, 1955, 15 cases (representing 8 men, 10

women and 25 children) were provided with temporary accommodation due to eviction from houses or rooms or inability to find suitable lodgings, the highest number maintained in any one week being 19 persons (4 men, 4 women and 11 children). The 15 cases consisted of 9 family units. On the 31st March, 1955, temporary accommodation was being provided for 3 men, 4 women and 11 children..

The accommodation at Whitehaven is in the former casual ward which ceased to be used as such in 1949, and it was intended that the former casual ward block at Wigton (a separate unit closed at the beginning of the 1939/45 war) should, in the process of the final rearrangements for upgrading Highfield House for elderly persons in need of care and attention, be suitably adapted and used as temporary accommodation on a unit basis for the eastern part of the county. Having regard, however, to the urgent and pressing need for increased hospital bed provision due to the subsidence at Meadow View House, Whitehaven (see observations in the earlier part of this report) the casual ward at Wigton is now being adapted as a 15 bed temporary annexe to the hospital.

However desirable it is that homeless families, and especially mothers with children, should be kept together as individual units in an endeavour to avoid the break-up of family life, the maintenance of such units in buildings neither designed nor really suitable for the purpose, does present administrative difficulties, especially so when the buildings depend for all services (including feeding) on the main institution. In these conditions it is not a practical proposition to make families individually responsible for providing the services they need.

With a view to providing premises more suitable for the purpose, negotiations have been opened up with the government department concerned for the renting by the council of a number of huts on a wartime camp site where, subject to a certain amount of supervision by the warden on the site, homeless families would be required to fend for themselves in the way of preparing meals, laundry requirements and the cleanliness of the respective quarters, one important principle being that, if accommodation is made too comfortable and convenient, there is little effort on the part of home-

less families to seek accommodation elsewhere. Such a scheme would also have the additional advantage of preventing the association of young children with elderly inmates in a mixed institution.

On the general question of temporary accommodation for evicted families the arrangement, effected some time ago, whereby local housing authorities supply information regarding potential cases of eviction, continues to operate. Defaulting tenants are interviewed, advised of the consequences which might follow eviction, and as to the nature and cost of accommodation which might have to be provided for them. As previously mentioned, this arrangement has had the effect of some defaulting tenants seeing the error of their ways, with a consequent staying of eviction proceedings.

Old People's Welfare — Voluntary Effort

The Cumberland Old People's Welfare Committee continues to stimulate and develop voluntary interest in the well-being of aged persons living in their own homes, in an effort to increase the number of local Old People's Welfare Committees in urbanised areas and the expansion of the novel scheme of "old people's friends" in the rural areas, and apart from mentioning the introduction of a "meals on wheels" service by the Penrith Local Committee, there is little one can add to the previous report. Every support continues to be given to the voluntary committee in the furtherance of its efforts in the direction indicated.

Welfare Services for the Blind, Deaf and Dumb etc.

Whilst the value of these services cannot be over emphasised, they are now so firmly established on clearly defined lines that there is little change to record from year to year, although much help and advice continues to be given to the council's agents on matters of general administration and individual problems.

The agency arrangements with

(a) the Cumberland & Westmorland Home and Workshops for the Blind;
(b) the Barrow, Furness & Westmorland Society for the Blind; and
(c) the Carlisle Diocesan Association for the Deaf and Dumb;

have continued throughout the year, and quarterly reports on various aspects of the services have been presented to the Welfare Committee.

(a) **Blind**

Taking into account new admissions to the register, de-certifications, removal and deaths, the number of registered blind persons in the administrative county shows an increase of 35 during the year under review. Actually the number of new admissions to the register was 76. The total number of blind persons registered on the 31st March, 1955, was 499, classified as follows:-

Age Group.	Males	Females	Total
0- 5	—	2	2
6-10	2	1	3
11-15	2	—	2
16-20	2	4	6
21-30	6	6	12
31-39	14	11	25
40-49	14	11	25
50-59	29	30	59
60-64	17	24	41
65-69	20	35	55
70+	110	159	269
	216	283	499

In addition, there are 66 persons registered as partially sighted.

The erection of new workshops at Petteril Bank, Carlisle, has been completed, and whilst a date for the official opening has not yet been fixed, arrangements are being made for the closing down of the workshops in Lonsdale Street, Carlisle, and the transfer of operations to the new premises as from the 4th July, 1955. So far as space and working conditions are concerned, the new premises, when fully equipped, will provide ideal facilities for sheltered employment, which it is hoped to extend in the near future to other handicapped persons not suitable for employment in open industry.

The Cumberland and Westmorland Home and Workshops for the Blind also act as agents to the Carlisle County Borough Council and, as will be seen from the attached report (see Appendix I), which gives a picture of the organisation and service as a whole for that part of the geographical county covered by the agency arrangements, the welfare services provided for the blind are very comprehensive.

In the report there is a reference to clubs and social centres, and it will be of interest to here record that, arising out of a scheme sponsored by the Work-

ington and District Amateur Musical Society for the construction of a garden for the blind in Workington Corporation's Vulcan Park, a suggestion was put forward that the scheme might be amended by the provision of a permanent club room for the blind, an amenity for which there was an urgent need, but the Society did not think it proper that monies raised for the specific purpose of a garden for the blind, should be diverted to any other use.

Under the Welfare Services Schemes for the Blind, Deaf and Dumb and other handicapped persons, the County Council is required, amongst other things, to promote the general social welfare of all three categories of handicapped persons by encouraging them to take part in the activities of social centres, clubs or institutions and, in addition, may themselves provide social clubs and recreational facilities. Accordingly, and after consultation with their agents operating the respective schemes, the County Council approved a plan (as a pilot scheme for the county) for the building in Workington of a club room or social centre, estimated to cost approximately £4,000, the cost to be shared as follows:—

(a) Capital cost of building estimated at about £4,000: To be borne by the County Council.

(b) Furnishings: To be borne—⅓ Cumberland Home and Workshops for the Blind; ⅓ Carlisle Diocesan Association for the Deaf and Dumb; ⅓ other handicapped persons for whom the County Council would be responsible in the absence of any recognised voluntary body.

(c) Maintenance Costs (including heating, lighting and caretaking): To be borne—⅓ Cumberland Home and Workshops for the Blind; ⅓ Carlisle Diocesan Association for the Deaf and Dumb; ⅓ other handicapped persons (County Council for the time being).

The Workington Town Council readily agreed, subject to Ministerial approval, to grant a lease of the proposed site in Vulcan Park on which to erect the social club and the project has been included in the County Council's Capital Building Works Programme for 1955-56 for approval by the Minister of Health.

(b) **Deaf and Dumb**

The Carlisle Diocesan Association for the Deaf and Dumb (affiliated to the National Institute for the Deaf) operates throughout the geographical counties of

Cumberland and Westmorland, the Furness area of the Lancashire County Council, and in the area of the County Borough of Barrow-in-Furness, and is the only association in those areas providing a welfare service for deaf and dumb persons of all denominations. The association has institutes in Carlisle and Barrow, with centres in Kendal and Workington, where the deaf and dumb may enjoy special services by means of finger spelling and gesture.

In the whole area on the 31st March, 1955, there were 245 deaf and dumb persons on the registers distributed and classified as follows:—

Category	Cumb. West. C.C.	Lancs. C.C.	Barrow. C.B.C.	Carlisle C.B.C.	Total
School age or under ...	13	4	2	8	12	39
In Institutions	—	3	1	—	1	5
In Mental Hospitals ...	4	—	1	—	1	6
In full-time employment	60	10	8	11	22	111
Married women at home	16	3	2	4	12	37
Single women at home	7	1	2	4	—	14
Unemployed—age ...	6	2	1	4	6	19
Unemployed—infirmity .	2	1	1	—	—	4
Unemployed	3	—	1	1	1	6
Private means	—	—	—	1	3	4
	111	24	19	33	58	245

During the twelve months under review, 996 visits were made by members of the association staff to deaf and dumb persons in the area, the number including routine visits to persons who are unable because of distance, isolation or other reasons, to attend the institutes and social centres in Carlisle, Barrow, Kendal and Workington. Visiting often brings to light personal problems in the solution of which the visiting Missioner can offer advice and help.

On the question of social centres, a reference will be found in the previous section of this report relating to welfare services for the blind, to the proposed building of a club room or social centre in Workington for use jointly by blind, deaf and dumb and other handicapped persons. The proposal has been greatly welcomed by the Diocesan Association as an amenity for which there is a real pressing need in connection with the development of social facilities in West Cumberland.

In regard to the work of the association, I have attached to this report as Appendix II, a statement giving a summary of activities during the year to 31st March, 1955.

The association continues to develop and expand its services and one feels well satisfied with the continued progress and the present trend to remould the service more in keeping with local authority practice whilst in no way destroying or interfering with the purely voluntary side of the work.

(c) **Other handicapped persons**

Under the scheme of welfare services for handicapped presons other than the blind, partially sighted and deaf and dumb—the more important features of which were detailed in last year's report—the first requirement was the compilation of a register which would give a complete classification of persons and the different categories of disability. Whilst information from the Ministry of Labour's register of disabled persons cannot be given without an individual's consent, the position is that not all such persons will be in need, or desirous of taking advantage of the services which the County Council can, or may, provide, in that a fair precentage with minor disabilities will presumably be in paid employment. In co-operation with the local office of the Ministry, forms of application for registration with the County Council were issued to registered disabled persons, and up to date something like 270 applications have been received. Whilst there were over 3,700 persons in the county registered under the Disabled Persons (Employment) Act, 1944, one cannot think that the 270 applications so far received represents the total of other handicapped persons who might wish to take advantage of some of the services provided under the scheme. Again, initial registration is only the beginning of the venture, in that each application will have to be followed up by an investigation on the spot, firstly to ascertain the nature and degree of the disability, and secondly the extent to which the persons concerned are in need of, or would benefit from, any of the services to be provided.

The scheme which covers such services as (a) social welfare; (b) workshop and home employment; (c) employment in open industry; (d) handicrafts and other skilled activities; (e) marketing of produce; (f) social centres and holiday homes, etc.; is on somewhat similar lines to the welfare scheme for blind persons, and provides for the appointment of welfare officers for the efficient discharge of the functions.

It will be recalled that in a report to the "Manpower" Committee, which showed a reduction of 50% in the staff complement of my department as a whole compared with 31st March, 1948, reference was made to the need for an additional administrative assistant to cope with existing and new schemes. By the transfer on the 31st March, 1955, to matrons of children's homes and the staff of the children's department, of certain administrative functions hitherto carried out in my department, the position has been eased to the extent that the first requirement of registration is now well in hand, and a way has been cleared to get to grips with the scheme and thereby obtain a more realistic picture of what will eventually be involved. It is obvious though, that in the near future one or more welfare officers, exclusive to the service, will have to be appointed for actual "field" work if the scheme is to be fully implemented.

It is possible that this scheme may in time well dwarf in size and financial considerations the scheme for deaf and dumb persons, and reach parity with, or extend in importance beyond, the blind persons welfare scheme. Inherent in the building of new workshops for the blind at Petteril Bank, Carlisle, is the utilisation of the premises for sheltered employment for handicapped persons other than the blind, another matter which will need very close consideration before implementation, as also will the question of hostel facilities.

Certain cases have already been dealt with and assistance given, but it can only be by a process of careful timing, with due regard to the financial considerations which may be involved, that the full benefits of the scheme will accrue to those handicapped persons for whom the services are intended.

Reception Centres
Persons without a Settled Way of Living

The act imposed a duty on the National Assistance Board to make provision whereby persons without a settled way of living may be influenced to lead a more settled life, and to provide and maintain centres to be known as "Reception Centres" for the provision of temporary board and lodging for such persons. The act also empowered the Board to require county and

county borough councils to provide and maintain reception centres, subject to reimbursement by the Board of approved expenditure in carrying out this agency duty.

In the administrative county there is only one reception centre which is at Station View House, Penrith, an establishment providing Part III. accommodation and treatment for a number of chronic sick patients, together with a maternity unit (R.H.B.). The centre at Meadow View House, Whitehaven, was closed on the 1st March, 1949, and if wayfarers turn up and it is not possible by way of public transport to get them to the nearest open centre, they are given accommodation for the night.

The County Council have carried out the duty since 5th July, 1948, and the following table shows the number of wayfarers dealt with :—

Year ended	Penrith				Whitehaven			
	M.	W.	C.	Total	M.	W.	C.	Total
31.3.49 (9 mths. only)	812	28	—	840	152	6	—	158
31.3.50	1822	74	4	1900	54	3	4	61
31.3.51	2403	90	4	2497	28	2	1	31
31.3.52	2694	144	6	2844	6	2	—	8
31.3.53	3337	135	1	3473	2	3	—	5
31.3.54	3331	129	5	3465	3	4	1	8
31.3.55	2727	174	4	2905	—	—	—	—

It has been repeatedly stressed that the presence of casual wayfarers in and around Station View House, Penrith, has a detrimental effect on the standard and services therein provided, and a proposal was put forward by the writer to the National Assistance Board some $2\frac{1}{2}$ years ago, that the reception centre at Penrith should be closed and a new one established in certain hutted building (crown property)—the Merrythought Hostel—on the main Penrith-Carlisle road.

The latest information is that the Ministry of Works are still engaged on detailed drawings, etc., in connection with necessary adaptations to the huts and that it seems likely it will be towards the end of the year before the hostel will be ready for occupation as a reception centre. As soon as the Board is in a position to do so, they will give a precise date for occupation. There the matter stands on the day of the conclusion of this section of the report (i.e. 21st July, 1955).

Civil Defence

Issues connected with civil defence, and in particular those relating to the welfare section, continue to receive considerable attention. It is of importance to note that this section, hitherto looked upon by many as the "Cinderella" of the services, has of recent months risen to its rightful place in the structure of civil defence. Much remains to be done, not only by way of further recruitment to the section, but also in the training of some 1,400 recruits under the new combined syllabus, an issue to which particular attention will be given during the coming winter months.

General Observations

During the year the general day to day administrative arrangements have proceeded smoothly, and collaboration established where necessary with the various government departments concerned, and other sections of the county administration, where services additional to those provided under the National Assistance Act could be invoked for the benefit of individuals concerned. Helpful advice continues to be given to many persons on issues completely outside the statutory duties of the County Council.

What has been set out above must not be taken as an exhaustive survey covering the whole field of activities of the welfare committee. This report merely touches upon some of those main features of the administration which it is thought would be a useful supplement to the County Medical Officer's report for 1954.

In concluding this report, I would like to express my grateful thanks to members of the County Council, and especially to the chairmen and members of the health and welfare committees and the various house management committees, for their great interest in the advancement and expansion of the welfare services as a whole, and to record my appreciation of the efficient co-operation and help given by members of my staff throughout the year.

W. C. WALKER.

County Welfare Officer.

CUMBERLAND AND WESTMORLAND HOME AND WORKSHOPS FOR THE BLIND

Welfare Services, etc., for blind persons resident in the Administrative County of Cumberland and the City of Carlisle.

1 REGISTER

The number and classification of Blind Persons on the Register on the 31st March, 1955, was as follows:—

Age Group.	Males. City.	Males. County.	Females. City.	Females. County.	Total. City.	Total. County.
0— 5 ...	—	— ...	—	2 ...	—	2
6—10 ...	—	2 ...	1	1 ...	1	3
11—15 ...	2	2 ...	2	— ...	4	2
16—20 ...	1	2 ...	1	4 ...	2	6
21—30 ...	2	6 ...	3	5 ...	5	11
31—39 ...	4	14 ...	6	11 ...	10	25
40—49 ...	1	13 ...	5	9 ...	6	22
50—59 ...	3	28 ...	7	26 ...	10	54
60—64 ...	4	17 ...	2	24 ...	6	41
65—69 ...	7	19 ...	6	35 ...	13	54
70+ ...	22	100 ...	20	152 ...	42	252
Total ...	46	203 ...	53	269 ...	99	472

2 WORKSHOPS.

(a) **Types of employment and numbers employed on 31st March, 1955 (excluding Trainees).**

Trade	Males City	Males Cnty	Females City	Females Cnty	Total City	Total Cnty
Firewood Department	2	3	—	—	2	3
Bed and Mattress Making	1	3	1	—	2	3
Bedding Labourers ...	—	2	—	—	—	2
Brush Making ...	1	2	—	—	1	2
Basket Making and Rush Seating ...	2	2	—	—	2	2
Upholstery	—	2	—	—	—	2
Piano Tuning	—	1	—	—	—	1
Machine Knitting ...	—	—	3	3	3	3
Re-seating Chairs (in cane)	—	—	—	1	—	1
Total	6	15	4	4	10	19

General Observations on Employment.

All employees in the workshops have been afforded full time employment, the mattress makers in particular having a year-end rush to effect delivery of 200 mattresses to a local hospital before the 31st March. Other govern-

ment contracts are proceeding which, together with the seasonal rush of work, will keep the mattress shop at top pressure for some little time.

The brush shop continues to be well supplied with work and manages to keep pace with deliveries.

The basket makers are also well supplied following an influx of orders for laundry hampers in preparation for the coming holiday season. The knitters too are fortunately placed in that the department, generally, can rely on a steady flow of private orders, school stockings and similar.

(b) **Training.**

Blind Persons at 31st March, 1955, receiving training with the approval and recognition of the Ministry of Labour:—

Training in.	Males.			Females.			Total.		
	City.	Cnty.	Others.	City.	Cnty.	Others.	City.	Cnty.	Others.
Basket Making ..	—	—	1	—	—	—	—	—	1
Brush Making ..	1	—	—	—	—	—	1	—	—
Machine Knitting	—	—	—	1	—	—	1	—	—
Total ...	1	—	1	1	—	—	2	—	1

General Observations on Training

At the close of the year application had been made to the Ministry of Labour and National Service for the approval of a further trainee from Workington in basket making and another from Barrow for machine knitting, sewing, etc.

(c) **State of Workshops—Adequacy of facilities.**

Not much progress has been made since the last report with the installation of machinery and equipment for the new workshops, but the subject is now well in hand and the committee has fixed the last week in June and the first in July as the probable removal date.

(d) **Blind Persons at 31st March, 1955, in Training at other recognised Centres:—**

Centre.	Training in.	Males.		Females.		Total.	
		City.	Cnty.	City.	Cnty.	City.	Cnty.
Yorkshire School for the Blind.	Machine Knitting	—	—	—	1	—	1
Royal Normal College	Shorthand and Typing	—	2	—	—	—	2
Total		—	2	—	1	—	3

(e) **Blind Children at Special and other Schools at 31st March, 1955:—**

School.	Males City	Males Cnty	Females City	Females Cnty	Total City	Total Cnty
Manchester	—	—	2	—	2	—
Prudhoe and Monkton Hospital	1	—	—	—	1	—
Fulwood, Preston	—	1	1	—	1	1
Sheffield School for the Blind	—	1	—	—	—	1
Sunshine Home, Southerdown	—	—	—	1	—	1
Total	1	2	3	1	4	3

3 OPEN INDUSTRY

(a) **Types of employment and numbers employed at 31st March, 1955**

Trade	Males City	Males Cnty	Females City	Females Cnty	Total City	Total Cnty
Factory Operatives	—	2	—	—	—	2
Labourers	1	3	—	—	1	3
Telephone Operators	—	2	—	—	—	2
School Teachers	—	—	1	—	1	—
Agricultural Workers	—	3	—	—	—	3
Physiotherapists	—	1	1	—	1	1
Poultry Farmers	—	4	—	—	—	4
Other open employment and St. Dunstaners not included above	1	4	1	—	2	4
Total	2	19	3	—	5	19

(b) **General Observations**

One labourer who was decertified during the latter part of 1954 has now recovered from his illness, returned to his work and is now classified as partially sighted.

Another man, registered as partially sighted, has returned to his former employment after nearly seven years absence through ill health. With these changes the number of partial cases in full time employment now totals 6.

4 HOSTEL—PETTERIL BANK.

(a) **Number of residents in hostel on 31st March, 1955**
County cases 6. City cases nil. Others 1. Total 7.

(b) **General observations on maintenance, social activities and other matters of interest.**

Two further trainees may take up residence in the hostel before the close of June quarter if their applications for training are approved by the Ministry of Labour and National Service.

The social club, made up of hostel residents and blind workers is again participating in the competitions of the North East Games Association of the Blind and their first fixture is at home against teams of blind men and women from Darlington.

5 HOME EMPLOYMENT (not part-time workers).

On the 31st March, 1955, there were 5 blind persons in the home workers' scheme in the following occupations.

	Males.		Females		Total		Visits in
	City	Cnty	City	Cnty	City	Cnty	Quarter
Braille Copyist	—	—	—	1	—	1	5
Piano Tuner	—	1	—	—	—	1	3
Farmer	—	1	—	—	—	1	1
Shopkeeper	—	1	—	—	—	1	11
Poultry Farmer	—	1	—	—	—	1	2

There has been no change in those included in the home workers' scheme during the year but a county female who was trained as a home teacher has been accepted for home employment as a braille copyist with the National Library for the Blind as and from 1st April. The business of the piano tuner and music dealer continues to expand with television and radio sales soaring and piano tunings and radio, etc., repairs in arrears. The shopkeeper continues as before with little or no improvement in sales whilst the pig and poultry farmer is making steady progress.

6 HOSPITALS, INSTITUTIONS AND HOSTELS (Other than Petteril Bank).

The number of blind persons in hospitals, institutions, homes and hostels on the 31st March, 1955, was as follows:—

Hospital, Institution or Hostel	Males		Females		Total	
	City	Cnty	City	Cnty	City	Cnty
Part III. Accommodation ...	—	6	1	6	1	12
Other Residential Homes ...	1	—	2	—	3	—
Mental Hospitals	2	2	2	1	4	3
Other Hospitals	—	—	2	2	2	2
Total	3	8	7	9	10	17

The reductions in the foregoing table are attributable to deaths and the removal of two partially sighted persons previously included. The remainder have all been visited regularly by the home teachers.

7 HOME TEACHERS.

No. of Home Teachers in County Area—5
„ „ „ „ „ City Area —1
— Total 6

Districts & Home Teacher	Cert. or Uncert.	No. of Blind Pers'ns in District	No. of Home Visits during Quart'r	No. of other visits on behalf of Blind
City—				
Miss Speight	Cert.	99	128	29
Cumberland Rural Areas—				
Miss Hetherington ...	Cert.	102	151	25
Maryport and District—				
Miss Morgan-Williams ...	Cert.	98	160	10
Workington, Whitehaven and Districts—				
Mr. Hilland (males) ...	Cert.	86	297	17
Miss Gander (females) ...	Cert.	96	270	50
Mrs. Todd (very old folks)	Uncert.	90	329	9

The last three months of the year has been a most depressing peroid for the home teachers who have experienced bad travelling conditions resulting from floods, snow and ice and unfavourable weather generally. Despite these difficulties and resultant periods of sickness due in no small measure, to the conditions, the home teachers have maintained a regular round of visits to and on behalf of the blind and partially sighted on the register.

8 HANDICRAFT CLASSES.

Location	No. of Class's held during year	Avge. atten-dance.	Individual lessons given	Instruction given in	Instructor
Penrith ...	19	7	128	Basketry Pulp Cane Work	Miss Hetherington
Cockermouth	24	7	168	Chair Caning Knitting	
Maryport ...	45	10	400	Weaving Rugs	
Whitehaven	51	9	297	Stool seating Embroidery Straw Bags	Mr. Hilland
Egremont ...	42	8	257	Netting Leathercraft Beadwork Crochet work	Miss Gander
Carlisle ...	38	10	386	String Bags	Miss Speight

General Observations

Attendances at classes during the twelve months fell as a result of weather conditions and illness but despite this the actual work done has increased in quality and quantity.

Of the seven regular attenders at the Penrith class five are totally blind and whilst all are now getting on in years they are still as enthusiastic as ever.
The Maryport and Cockermouth classes have made steady headway and numerous members have made such progress that they are able to make simple baskets without assistance and produce many novelties in cane, etc., in and for their own homes.
Attendances at the Whitehaven class are regular and the members have had a steady demand for seagrass stools and baskets. During the severe weather when some of the older members were unable to attend the classes, materials were delivered to their homes thereby ensuring a continuity of pastime occupation and at the same time helping to meet the demand for urgent orders.

Adverse weather and illness during the winter months reduced attendances at the Egremont class, but the interest of the members was not affected in any way. All goods have been sold, some having reached "markets" as far afield as New Zealand, Australia, Canada and South Africa. One member of the class, 79 years of age, has received orders for the class for 20 shoping bags, many of which she has made herself.

The city class have had a busy period and some of their products were displayed at the Hobbies and Handicrafts' Exhibition held in the covered market.

New Year parties were held by both the Egremont and city class. The latter at the home of one of the members when expenses were defrayed from class funds and additional chairs, cutlery, etc., supplied by neighbours.

In addition to the foregoing a county case has had instruction in chair caning at home and a city case taught crochet work whilst a temporary patient in the City General Hospital.

9 CLUBS.

Social Clubs and Social Centres for Blind Persons are as follows:—

Location of Club	Open i.e. Daily, Weekly, Monthly, etc.	M/ship. (B.P.)	Av. Attend. (B.P.)	Short note on Activities.
Penrith	Monthly	12	8	See following notes.
Cockermouth (incl. Maryport)	„	22	16	„ „
Whitehaven	Fortnightly	16	12	„ „
Workington	Weekly	56	44	„ „
Cleator Moor	Fortnightly	28	22	„ „
Carlisle	Monthly	27	16	„ „

General Observations and Report.

Occasions worthy of note in club activities during the March quarter are always few as it seems to become a period of quiet after the rush of Christmas activities and, like the handicraft classes, average attendances are smaller because of severe weather and illness.

On February 7th Penrith club were entertained to an enjoyable afternoon by the Penrith Inner Wheel Club who provided a substantial tea followed by games and singing.

The Cockermouth club has had another successful year, thanks to the members of the Cockermouth Inner Wheel who supervise the tea and provide the entertainment.

Whitehaven club meetings have followed the usual routine of community singing, dancing, talks, dominoes, tea, etc.

Workington and Cleator Moor clubs have followed a similar pattern except that each have had a birthday party on 8th February and 19th January respectively when the Workington Party was attended by Councillor and Mrs. Davis (Mayor and Mayoress of Workington) and Mr. A. C. G. Thomson, chairman of the executive committee of the workshops. At both parties an excellent tea was provided and for those members who were unable to attend at Cleator Moor, their teas were sent home to them.

The city club had a talk on "Old Carlisle," by Mr. T. Burgess, Managing Director of the "Cumberland News," and in March the annual bulb growing competition, when Mr. J. C. Irvine, Parks Superintendent, judged the entries which he stated were a definite improvement on last year.

10 BRAILLE AND MOON—READERS AND INSTRUCTIONAL ACTIVITIES.

	City. Braille.	City. Moon.	County. Braille.	County. Moon.
(a) No. of readers registered with the National Library (Northern Branch)	19	2	21	8
(b) No. of other readers	3	3	5	—
(c) No. of blind persons receiving lessons in braille and/or moon	1	—	3	—
(d) No. of lessons given during the quarter	7	2	14	—

General Observations.

The county case, stated in the last report to be " trying out " braille has completed her lessons and now needs practice only to attain greater speed. The partially sighted county case similarly mentioned has almost mastered grade II. braille. Her husband continues to help and being a keen pupil she spends some hours each day practising and learning.

The county blind and spastic child has had regular lessons and whilst progress may be slow it is nevertheless satisfactory. Another young county male, recently registered, having had lessons in braille will require a good deal of encouragement if he is to continue as he is finding braille type most difficult.

A city male having completed his lessons in moon has not become a member of the library as he prefers magazines to books. He is fond of walking, a bell ringer at the Cathedral, and appears to have plenty to occupy his time. Another city case receiving lessons in braille is making very slow progress as the result of ill health which has now lasted some time.
In addition to the foregoing two partially sighted people, one city and one county, are receiving lessons in braille and moon.

11 GENERAL SOCIAL ACTIVITIES, ENTERTAINMENTS, OUTINGS, ETC.

The general social activities during the year have been maintained at the usual level.

12 WIRELESS SETS AND TALKING BOOKS.

The British "Wireless for the Blind" Fund hope to meet the need for wireless sets in full this year and part of the allocation of sets had been delivered. Thirteen privately owned talking book machines and eight the property of the workshops for the blind are all in regular use and retain their popularity.

13 HOME HELP SERVICE AND GENERAL MATTERS OF INTEREST.

The numbers availing themselves of the benefits of the home help service remain as before and all are unanimous in their appreciation of the service particularly the elderly people, some of whom, crippled or bedfast, as well as blind, have help daily. Others have help twice or thrice weekly and their houses are kept clean and tidy.

County applicants have had clothing from the Women's Voluntary Service and through the voluntary funds of the workshops, whilst further grants have been made towards the advance-booking payment for holidays. A further county case has received a voluntary pension of £20 per annum payable half yearly.

In the city, "Signature Guides for Pension Books" have been issued to a number of the blind people and braille and moon magazines viz.: World Digest, Madam, The Light of the Moon and others are purchased and circulated amongst those of the blind people who read the raised types.

Birthday cards are sent on the birthdays of blind people 70 and over and in many instances this card is the only recognition of the anniversary. In this connection two birthdays were celebrated in the county, a male having attained 90 years of age, and a female 99, when presents of a half bottle of whisky and a warm cardigan were taken to them. In all cases the home teacher's visits on or as near the birthday as possible are much appreciated.

CARLISLE DIOCESAN ASSOCIATION FOR THE DEAF AND DUMB.

SUMMARY OF ACTIVITIES DURING THE TWELVE MONTHS ENDING 31st MARCH, 1955

General

The committee is grateful to the subscribing public for continued support, and to the local authorities in the area for substantial grants, enabling the work of the association to be maintained and improved during the year ending 31st March, 1955.

House to House Collections

Difficulty has been experienced in the recruitment of a house-to-house collector in place of Mr. Holmes who retired on 31st March, 1954. A successor worked for part of the year only before leaving for other employment. Collections have been fairly well maintained, however, and the estimated income from this source was just reached at £1,408.

Staff

The vacancy for an assistant missioner to work in the West Cumberland area has been considered, and after extensive advertising the appointment was offered to Mr. H. Wilcock of Wakefield, a deaf man of ability who has given many years' voluntary service to the deaf and dumb and who wishes to make this work his career. The help of the Workington Town Council has been sought in the matter of providing a house for Mr. Wilcock and his family.

West Cumberland Centre

The association is particularly grateful to the Cumberland County Council for a generous offer to build a social centre in Workington for the joint use of the deaf and dumb, the blind, and other handicapped persons. The committee has accepted this offer on behalf of the deaf and dumb and has agreed to meet one-third of the cost of the necessary furnishings.

Staff Superannuation

Cumberland County Council has approved the association's application for the entry of eligible members of its staff to participation in the benefits of the council's superannuation scheme. This has been made possible by the provisions of the Local Government Superannuation Act, 1953.

Property Maintenance

Maintenance work done on the property in the year has included part re-decorating in the Carlisle institute and the rebuilding of a dwarf boundary wall at the institute in Barrow.

Kendal

The Committee records its acknowledgment of the valuable help given to the association by the Kendal branch of the Toc H in the continued provision of social amenities for the deaf and dumb people of that town.

Hard of Hearing

The Carlisle institute has been used weekly throughout the year by the Carlisle hearing aid club, for meetings and social purposes. The hearing aid club kindly donated a sum of ten pounds towards the association's funds as an acknowledgement.

Affiliations

Affiliation with national and regional organisations engaged in work for the deaf and dumb has been maintained.

Annual Meeting

The annual general meeting was held on September 29th in the Carlisle institute. After the usual business of an annual meeting, a documentary film was shown entitled " Triumph Over Deafness " being introduced by Councillor J. C. Salkeld of Appleby, who was himself at one time a teacher of deaf children.

Social Activities

The institutes in Barrow and Carlisle have been in regular use all through the year, on several evenings each week. The institutes are equipped for all the usual indoor games, and have television sets and canteen facilities. There have been whist drives and special socials in each institute and visiting clubs of both deaf and hearing people have been entertained. Fortnightly meetings have been held in St. Michael's Church Hall, Workington, with kind permission of the vicar and church council, to cater, in a temporary manner, for the social needs of the deaf people of West Cumberland. Arrangements were made for motor coaches to carry deaf members from one town to another for fraternal inter-centre visits. A joint summer outing to Bowness-on-Windermere was organised for the Carlisle and West Cumberland members, who were joined there by some from Barrow. In September three coaches of members from Kendal, Carlisle and West Cumberland travelled to Middlesbrough to take part in the northern rally organised by the British Deaf and Dumb Association. Christmas parties or annual re-unions were held in each centre, and a special party with Santa Claus was arranged for deaf school children in Carlisle. Parcels of gifts were taken to the homes of deaf children in the country who were not able to attend. In the Carlisle institute, the billiards table, which was getting the worse for wear, has been re-covered with a good quality cloth through the generosity of Dr. Overton, a member of the Diocesan Committee.

Visiting

Nearly one thousand visits have been made to the homes of deaf people in the district. Those who live in the towns and attend the institute and social centres have not been visited except in cases of sickness or other special need, but regular visits have been paid to those who live at greater distance.

Employment

The employment of Deaf and Dumb persons throughout the region has remained most satisfactory. Cases of unemployment have been very few, and usually of a temporary character. Whenever required,

the association has been ready to assist the deaf and dumb, employers, or the Ministry of Labour, in any matter affecting employment. There were very few "difficult" cases during the year.

Individual Problems

Very many different kinds of problems are brought to the association by the deaf and dumb, in which they need help or advice. Most of these require interpretation in the finger and sign language. During the year interpretation has been supplied whenever needed in many different ways, for example, in labour exchanges, banks, insurance offices, registrars' offices, police stations and courts, weddings, funerals, hospitals, solicitors' offices, and workshops. The association has tried to be a link between the deaf and dumb and the community in general.

Religious Services

Religious services, conducted in finger and sign language, have been held regularly in all four centres. Harvest festivals with special visiting preachers, were arranged in the chapels in the Carlisle and Barrow institutes, and Barrow had an anniversary service to commemorate the dedication of their new chapel. Holy Communion has been celebrated by the district Hon. Chaplains, assisted by interpretation.